NSWCCL SUBMISSION

VOLUNTARY ASSISTED DYING BILL 2017

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About NSW Council for Civil Liberties

NSWCCL is one of Australia's leading human rights and civil liberties organisations, founded in 1963. We are a non-political, non-religious and non-sectarian organisation that champions the rights of all to express their views and beliefs without suppression. We also listen to individual complaints and, through volunteer efforts, attempt to help members of the public with civil liberties problems. We prepare submissions to government, conduct court cases defending infringements of civil liberties, engage regularly in public debates, produce publications, and conduct many other activities.

CCL is a Non-Government Organisation in Special Consultative Status with the Economic and Social Council of the United Nations, by resolution 2006/221 (21 July 2006).

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The Council for Civil Liberties (NSWCCL) thanks the NSW Parliamentary Working Group on Assisted Dying for its invitation to make a submission concerning the Voluntary Assisted Dying Bill 2017.

CCL applauds the construction of the draft Voluntary Assisted Dying Bill (the Bill), and supports its passage. If arguments are raised against its adoption that are not dealt with below, we would welcome the opportunity to refute them.

Introduction

Since its inception, the Council for Civil Liberties has had a policy of supporting the legalisation of assisted suicide and voluntary euthanasia. In the last two decades, this has been manifest in our support for the Northern Territory's Rights of the Terminally Ill Act 1995, our opposition to the Euthanasia Laws Bill 1996 (Cth) which, when passed, overrode that Act, our support for the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008, which would have restored the power of the Northern Territory Government to re-enact its rights of the terminally ill legislation, for the Rights of the Terminally Ill Bill 2013 (NSW), and for the Voluntary Assisted Dying Bill 2016 (NSW).

We note that five countries have legislation for voluntary euthanasia, five more have legislation for assisted suicide, as do seven states of the United States. Contrary to commonly made predictions, there have not been reports that we can discover of a wave of atrocities as a result of these laws. There has been no slippery slope, nor decline in the value accorded to human life. There have been no credible reports that the standard of ethical behaviour by doctors has deteriorated.[1]

Terminology

Distinctions are routinely made in the literature on euthanasia between active and passive euthanasia and between voluntary, non-voluntary and involuntary euthanasia. Active euthanasia is doing something which speeds the death of a dying person who is suffering intolerably. Passive euthanasia is allowing a person to die, because they are suffering intolerably. Voluntary euthanasia is done because the person wants it. Non-voluntary euthanasia is done when the person is unconscious and cannot be asked for his or her decision. Involuntary euthanasia would be something done in spite of the person's wish to stay alive, or a refusal to take action that would keep a person alive, when they want that action taken.

[1] For detailed support for this view, see the podcast series, 'Better Off Dead' produced early in 2016 by Andrew Denton.

Because the Bill is concerned only with voluntary assisted dying, this submission is only concerned with the arguments for and against making that legally permissible in appropriate circumstances.

However, the distinction between non-voluntary and involuntary euthanasia is important—and was not well understood (or was deliberately confused) by some of those who made submissions to the Legal and Constitutional Committee of the Senate in 1997.

We note also that voluntary passive euthanasia (allowing someone to die of a curable disease, such as pneumonia, in order not to prolong pointless suffering) is common. Here, the intention that the patient should die in order to end their suffering, and the outcome, death, are the same as those of assisted suicide. There is no significant moral difference between these two procedures.[2]

Minor amendments that might be made to the bill

While we recognise that the requirement for a certificate by a psychiatrist provides a protection for the other two doctors as well as for the patient, we are concerned that patients in rural hospitals may not have ready access to an independent psychiatrist to carry out this task. We note that the Oregon, USA legislation permits the equivalent task to be carried out by two laymen. CCL recommends that the committee consider permitting two laymen to act where no independent psychiatrist is available.

In some cases, a person may fail the psychiatrist test on one occasion, but be capable of making the necessary decision on another—perhaps the next morning. There is nothing in the Bill to prevent a second assessment, but perhaps a note could be added making this clear.

We are concerned by the very conservative limitation to people over the age of 25. Such measures are available to juveniles, for instance, in Belgium.

NSWCCL position

Subject to the consideration of the above suggested improvements, the Council for Civil Liberties supports this Bill as a positive step towards the much needed

[2] There are many are cases where there *is* a moral difference between killing and letting die, but invariably, in those of which CCL is aware, the moral difference is due to factors other than the bare difference between action and permitting an outcome which account for that moral difference.

legalisation of voluntary assisted dying in New South Wales. The passage of such legislation is long overdue.

Recent surveys have shown that an overwhelming majority of New South Wales citizens support making assisted suicide available—72%, with only 16% opposed, in a survey of 34,000 residents, conducted in 2015 by the Australian Broadcasting Corporation; in an Australia-wide survey in 2016, 75% supported, with only 16 % opposed.

Detailed argument

The principal argument for legalising voluntary assisted dying is that terminally-ill competent adults with irremediable, intolerable suffering should not be left to suffer, but should have the right to choose to end their own suffering.

"Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence."[3]

Here are some real case studies.[4]

Patient One. In 2000, this patient had a bone infection which was widespread after a misdiagnosis of gout. Attempts to stop the infection with antibiotics led to his kidneys ceasing to function. He was admitted to a prominent Catholic hospital, where efforts to restart his kidneys failed. His death was seen to be inevitable. The pain caused by a single kidney malfunctioning is excruciating. He suffered from two, and from the bone infection as well. All efforts at pain relief failed. He was in agony, for some days. This life-long conservative Catholic begged everyone—medical staff, his relatives and friends, to end his life. He was told 'you know we can't do that'. At last, he was given a sufficient dose of morphine, and died soon afterwards.

Patient Two. Suffering from pancreatic cancer, this patient was told near the end of 1997 he had a few months only to live. He was admitted to a hospice, where his pain was treated with morphine mixtures. Although he was kept from severe pain, he suffered instead from nausea and other unpleasantness. He repeatedly declared that he felt dreadful, and wanted to die. After some weeks, his medication was changed, and he died within 48 hours.

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[3] Cruzan v Missouri Director of Health 497 US SupremeCourt 261 (1990) at 310, Justice Brennan dissenting.

[4] Real examples have advantages over hypotheticals and generalised argument—they are not purely theoretical, and the full circumstances are known. For privacy and legal reasons the identities of these two patients have been suppressed, but verification can be provided with a bona fide request to the office of the NSW Council for Civil Liberties.

Patient Three. Andrew Denton reports[5] a patient in a nursing home, screaming every two hours for a fresh dose of morphine. For a week.

Patient Four. This patient was in the advanced stages of Alzheimer's disease, for months no longer aware of anything around her. She developed pneumonia, and was initially treated for that by a locum tenens administering care while her regular doctor was on holiday. When her doctor returned, he argued that there was no point in continuing treatment, and the patient was allowed to die peacefully—from a treatable disease. (This is an example of passive non-voluntary euthanasia. The clear intent was that the patient should die much more quickly than she would if the staff waited for an incurable illness to cause her death.)

To deny terminally ill persons like patients one and three their entitlement to die when they are in severe pain is cruel.

The principal argument is backed up by arguments supporting the principle of autonomy. The most famous of these is that of John Stuart Mill, who argues in On Liberty that:
...the sole end for which mankind are warranted, individually or collectively in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others...Over himself, over his own body and mind, the individual is sovereign.[6]

The right to life

Mill's arguments are consequentialist in nature. But the principle can also be argued for on non-consequentialist grounds. The crucial issue is whether assisted dying violates that right to life.

As CCL Vice President, Ms Pauline Wright, explained to the Senate Committee on Legal
and Constitutional Affairs in 1997:

> Those who are terminally ill, and who wish to, ought to have the choice to terminate their own lives with the assistance of medication. ... The moral argument that is most often advanced is that there is innate value in a human life. That is very hard to argue with. That is, of course, true. But so is the proposition that a person is in such suffering that they can no longer stand their life. Why should they be denied the right to terminate

[5] In 'Better Off Dead'

[6] Utilitarianism, Liberty, Representative Government, J.M. Dent & Sons London, 1962 pp. 72f

> that life in a way that is as easy as possible? It is their choice. If they choose that, we ought not deny it to them. It all comes down to choice. If a person disagrees with voluntary euthanasia for a religious reason, whatever reason it might be, that person does not have to exercise the right, but I don't think they should impose that moral or religious view - whatever their view might be - on those who do wish to die.

The UN Human Rights Committee has examined the issue of voluntary euthanasia in the context of the right to life, which is guaranteed in Article 6 of the International Covenant on Civil and Political Rights (ICCPR), and Dutch euthanasia laws. Significantly, the Committee did not find that a system of voluntary euthanasia violates the right to life per se. However, it stressed that strict procedural safeguards are required to ensure against abuse and undue influence and against the application of the system to anything other than extreme cases. The Committee expressed concern about the application of such laws to children aged 13 and over.

The Committee required the Netherlands to "ensure that the procedures offer adequate safeguards against abuse or misuse, including undue influence by third parties", to strengthen the pre-death safeguard procedures and to monitor closely the operation of the law.
The carefully considered analysis of the UN Human Rights Committee demonstrates that voluntary euthanasia is not necessarily contrary to the human right to life.

CCL notes that the Bill is carefully drafted and implements the safeguards recommended by the Human Rights Committee. We support their view as follows:

It true that we have a right to life. If we ask what it is about us that grounds that right, that makes us of significance—why we count in ways that animals do not, for example, or why it is in general wrong to kill us—the only answers that make sense are that we are capable of reason, and from our reasoning we choose the values by which we will live and die, and we can act on those values. It is as autonomous beings, thus understood, that we have our value, that we matter.

Subject to the harm principle, then, it is wrong to determine the values by which another person must live, for that is to deny him or her what is of ultimate importance, what makes him or her count. It is especially wrong to determine for another person the values by which he or she must die.

It is clear that, in the first three of the above cases, the desire to die and the patients' views that their lives were unbearable are rational. These are positions the patients are entitled to take and have implemented without interference from others.

Palliative care

Palliative care provides a successful intervention for many terminally ill patients. However, there are some people with intolerable pain and other forms of suffering for who0m palliative care is inadequate or inappropriate. The third example above was such a case. Bob Dent was one of just two sufferers who availed themselves of the Northern Territory's Rights of the Terminally Ill Act before it was overridden by the Australian Parliament. Before he died, he said 'I have no wish for further experimentation by the palliative care people in their efforts to control my pain...I cannot even get a hug in case my ribs crack. Being unable to live a normal life causes such mental and psychological pain which can never be relieved by medication'.

But even when palliative care reduces pain, as the second example shows, it may not be enough. People can scream in the last hours of their lives, in spite of powerful analgesics. Further, some people's intolerable suffering is for reasons other than pain.

Weak arguments against euthanasia

CCL notes eight arguments used to justify the State interfering with the sovereign right of terminally ill individuals to choose the time of their death. Many of these arguments were presented to previous inquiries into proposed assisted dying laws, and will probably arise again in this context. CCL offers the following observations on those eight weak arguments.

One: It has been argued that people who wish to be killed swiftly rather than to undergo the suffering and pain involved with their deaths lack courage. The assertion is itself a cowardly attack on the integrity of people dying in agony. If there were some point in their continuing to live—a close relative, perhaps, hurrying to be reconciled before it is too late—we might praise the patient's courage in not accepting a quick and easy death. Without such a point, it makes no sense to talk of courage.[7]

Two: It has been argued that life is a gift from God, and that to kill yourself is to throw the gift back in God's face. We might ask, in what sense was the last week of Patient One's life a gift? Would we say that the relief of pain is wrong, because God has given us the gift of pain? The argument is absurd— and supposes that God is a scoundrel.

[7] Lying down on the road to allow vehicles to run over you does not exemplify courage.

Three: It is argued that it is God who should determine the time a person dies, and that for the person herself (or someone acting for her) to do it is to play God. In response, it should be enough to note that the argument implies that we should not save a life that God has determined should end. Yet the argument keeps being brought up.

Four: It is argued that to legalise voluntary euthanasia is to change the role of the doctor. Doctors are concerned with saving lives, and for them to be asked to take lives instead changes how they perceive themselves, and how others perceive them. People, it is said, will not trust doctors who are known to kill.

First, if the Bill is passed, in most cases patients will kill themselves. Doctors will only provide the diagnoses and the means.

Second, a doctor should be committed above all to the welfare of her patient. Mostly, that will involve improving the quality of life, as well as lengthening it. Sometimes there is a choice between quality and length, and the choice is given to the patient. A patient may decline a particularly onerous or unpleasant course of treatment. The role of the doctor is to discuss the options and their consequences, and to help to improve the life the patient has chosen, not to determine the course of life of the patient.

Third, how do people perceive a doctor who refuses to relieve intense suffering? Will they trust such a person? Will they not rather trust someone who puts their welfare first?

Fourth, it is sometimes, at present, the role of a doctor to decline to lengthen life, when there is absolutely no point in doing so.

Five: It is argued that modern methods can relieve pain, allowing patients to die free from it. That is true of some illnesses. It was not true for Patient One. Moreover, our bodies get used to drugs, so that they become less and less effective. And as Patient Two's case illustrates, even when pain is relieved, a patient may still not find what is left of life is worth living.

Six: It is argued that if we allow the "easy" option of voluntary euthanasia, researchers will not make the effort they otherwise would to improve palliative care, both by relieving pain and by reducing or eliminating the side effects. This supposes that we should require patients to suffer intense pain, so that others will do what they ought to be doing anyway. This is obnoxious: a denial of the moral significance of the person, who is to be used, contrary to his or her own values, for others' benefit. This view also presupposes that everyone will choose voluntary euthanasia.

We have, moreover, been unable to discover any evidence to support the view that allowing voluntary assisted dying has led to any reduction in enthusiasm for research into palliative care.

Seven: It is argued that allowing euthanasia will be the thin end of the wedge. Once we accept that there are circumstances in which terminally ill persons may choose to die, we lose the certainty offered by the universal principle that life is always precious, and that it is therefore wrong to take life. We will then be forced, as a matter of logic, to accept other cases that are clearly morally wrong.

The thin end of the wedge argument is an argument about logic. F.M. Cornford calls it 'the doctrine of the dangerous precedent'.[8] It is, as he notes, invalid. If there is a real moral difference between two cases, accepting that one is permissible does not in any way commit us to the other. Each case should be argued on its own merits.

In any case, it is already widely accepted that there are exceptions to the principle that it is wrong to take life. Members of the French Resistance in World War II, for example, who took suicide pills rather than reveal secrets to the Nazis, are praised for their courage. The case of conjoined twins known as Jodie and Mary,[9] who were separated in an operation which killed Mary (this being the only way either could survive) is a second example. Despite the acceptance by many people that these actions were justified, there has been no attempt to justify more doubtful cases using these instances as precedents. That is, the wedge has not been driven in.

Eight: The slippery slope argument, by contrast, is a causal argument. It declares that once voluntary euthanasia is legalised for the obvious cases, we will move inexorably towards permitting killing in less clear cases, and that society will come to accept cases which it should not. The issue is why we should accept the assertion that we will be caused to move in the way described. No historical examples have been shown to support it. The assertion that there is a slippery slope is a mere hunch, a guess. The evidence from the countries that have legalised assisted dying is that there is no such slope.[10]

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[8] F.M. Cornford, Microcosmographia Academica, Metcalfe and Company, Cambridge, 1908, and available at Maths.ed.ac.uk

[9] In London, in 2000.

[10] See the Denton series of podcasts, passim.

Conclusion

Subject to the consideration of the suggested improvements above, the Council for Civil Liberties supports this Bill as a positive step towards the much-needed legalisation of voluntary assisted dying in New South Wales. The passage of such legislation is long overdue.

This submission was prepared by Dr Martin Bibby on behalf of the New South Wales Council for Civil Liberties. We hope it is of assistance to the NSW Parliamentary Working Group on Assisted Dying.

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