Chapter 2
Responses to the Bill

2.1 Many submitters to the inquiry commented on the broader policy issue of voluntary euthanasia, expressing both support for, and opposition to its introduction. The volume of submissions received, which included over 4700 pro forma submissions and over 700 additional submissions, indicated the community's broad engagement with this issue.

2.2 This chapter looks briefly at the main issues that were argued by each side of the debate.

Support for reform

2.3 Many submitters explained their support for the Bill on the basis that voluntary euthanasia is currently taking place and that it would in fact be better for there to be legislation regulating the practice.

2.4 Mr Peter Short, an individual with terminal cancer, explained this to the committee:

> …I very strongly believe, as I presently sit, that I will choose when and how I end my life. I would add to that, also, in terms of process and what goes on, it interesting to think about the concerns about ending life. Just to demonstrate, palliative care comes when you are a terminal person, and you are given this. It is an emergency pack. There are enough drugs in there to kill me and probably one or two of you. And that is just sitting in my house.
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> As well as that, over the course of the last six years I have not been able to sleep sometimes and I get a few aches and pains, so this is the standard set of three drugs I have: Diazepam, Ativan and valium. I do not use them very often but again there is enough drugs in there, sensibly prescribed, that would kill me. The issue is that I want to have a controlled process in an environment where I know that it is going to be a magnificent death and a magnificent ending not, as you mentioned before, swallowing a whole lot of pills, hoping it works and spitting half of them back up.[1]

2.5 Mr Short further explained that the possibility of having control over the process of his dying gave him an 'inner glow of certainty' of not having to worry when he gets to the stage of dying:

> If this bill passes, I may be the only person in the country that ever uses it—because, again, it is a choice—but it also alleviates my concern about how I will exit this world in terms of relationship with my wife and my child,

1 Mr Peter Short, *Proof Committee Hansard*, 15 October 2014, p. 31.

> because I know that, if I choose to, we can have a very sensible, peaceful conversation at a time of our choosing.[2]

2.6 These views were echoed by Professor Margaret Otlowski who informed the committee that empirical data 'drives the need for legislative reform':

> We need to recognise that euthanasia is occurring in practice and, in order to provide safeguards for patients, and also for doctors who provide such assistance, we need to put in place a legislative regime that allows appropriate scrutiny, support and regulation.
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> …it is not a question of whether we should commence to allow euthanasia, or for it to occur; it is already occurring. It is rather a question of: do we continue to ignore it and pretend that a prohibition is effective; or do we act more openly and honestly, and recognise that it is happening in practice, and put in place a regime that seeks to regulate it in a safe manner?
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> …in countries which prohibit euthanasia, not only is there still a similar level of practice but there is actually more danger to patients because there is a higher level of unrequested killing, because doctors clearly are not in a position to have open discussions and may act in the absence of an explicit request.
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> There is also a clear reluctance for legal authorities to get involved. There are doctors who are admitting involvement, through open letters in the papers and so on, but there are no follow-up prosecutions. Even if there were prosecutions, based on precedents from other jurisdictions, there is every likelihood that doctors would be dealt with leniently. I really want to emphasise that this is all pointing to the fact that current criminal prohibitions do not reflect common views of reprehensibility. There is a need for reform.[3]

The role of the doctor

2.7 Some submitters to the inquiry argued that the Bill may compromise the historical role of the doctor as healer, which is inextricably linked to the Hippocratic Oath.[4] This however, is a contested view. Ethicist Dr Bernadette Tobin, while expressing support for the Hippocratic conception of medicine, explained that there is a current 'battle of ideas' concerning medicine:

> I think that there is a battle of ideas, and a battle of practices, going on within the medical profession at the moment: between those who are committed to a Hippocratic conception of medicine—healing; making whole—which embodies teaching, curing where possible, stabilising a person in a reasonably satisfactory condition, relieving pain, improving the

2 Mr Peter Short, *Proof Committee Hansard*, 15 October 2014, p. 31.

3 Professor Margaret Otlowski, *Proof Committee Hansard*, 15 October 2014, p. 8.

4 Salt Shakers, *Submission 19*, p. 2; Catholic Women's League of Australia, *Submission 2*, p. 1; Organisation of Rabbis of Australasia, *Submission 34*, p. 1; Australian Christian Lobby, *Submission 48*, p. 10; Professor Anthony Radford, *Submission 50*, p. 2; Lutheran Church of Australia, *Submission 39*, p. 2; Family Council of Victoria, *Submission 85*, pp. 2–3.

> way a person dies, and that range of activities; and then those that have a different view of medicine, which is a kind of provider/consumer conception—so the doctor is the provider and he or she can choose whatever he or she wants to provide, and to whom, and under what conditions, and the patient is a consumer and can ask for whatever he or she wants, in whatever way and under whatever conditions. So there is a battle of ideas going on at the moment…the latter is what I have in my submission called the value-neutral, provider-to-consumer option, and the former is an ethically infused conception of medicine, which I have called Hippocratic, because it goes back to the Hippocratic Oath. In that oath, the point of medicine is explained, and the things that doctors, as doctors, will never do are also explained.[5]

2.8 Some submitters also suggested that the introduction of voluntary euthanasia would fundamentally undermine the relationship between a doctor and their patient. This was best expressed by Professor Roderick MacLeod who explained his concern that it would lead to an 'erosion of the level of trust between patient and doctor':

> Having legislation to legalise euthanasia or physician-assisted suicide would, I think, necessarily interfere with the bond of trust between doctor and patient.[6]

2.9 Professor MacLeod further explained:

> My sense is that part of the therapeutic benefit that I have with the people that I care for is built on trust. I would be concerned that if the patients thought, in building that sense of trust, that I might be the one that ended their life as well as tried to preserve their life, that would be a difficult thing for them to equilibrate. There is no evidence for that; it is just an opinion that I have that I see the key to effective medical care being based purely on trust.[7]

The slippery slope

2.10 Many submitters opposed to the exposure draft Bill suggested to the committee that introducing legislation to legalise voluntary euthanasia was a 'slippery slope' which would lead to euthanasia without specific consent or in non-terminal cases. Many submitters referring to the experience of Dutch Ethicist Theo Boer, himself an architect of the Netherlands voluntary euthanasia legislation. For example, the Catholic Women's League of Australia stated:

> In mid-July, as peers in the House of Lords in the UK, prepared to debate the Assisted Dying Bill, promoted by a Lord Falconer, Professor Boer urged them 'don't make our mistake' and warned of a 'slippery slope' to mass deaths. He further advised that assisted deaths have increased by

5 Dr Bernadette Tobin, Plunkett Centre for Ethics, *Proof Committee Hansard*, 15 October 2014, p. 36.

6 Professor Roderick MacLeod, *Proof Committee Hansard*, 15 October 2014, p. 23.

7 Professor Roderick MacLeod, *Proof Committee Hansard*, 15 October 2014, p. 23.

> approximately 15% every year since 2008 and the number could reach a record 6,000 by the end of 2014.[8]

2.11 The Australian Christian Lobby (ACL) explained:

> [W]e have clearly seen the slippery slope well and truly in action in Holland and in Belgium, in particular, where we have seen people being euthanised without their specific consent. That is not voluntary euthanasia.[9]

2.12 The ACL further explained:

> Once you go down this path, it is very hard to regulate the motives of people, whether it is family or others. There are very complex human motivations that come into end-of-life issues…And I think in reality you would be talking about this being available to a very, very small cohort of people who would fit a very narrow definition of what was acceptable. And then I think the question goes to whether hard and difficult and tragic cases make good public policy, good law, and I think generally we find as a principle of public policy that hard cases do not make good law.[10]

2.13 Mr Craig Wallace of Lives Worth Living raised a similar argument:

> Arguments about slippery slopes often have the odour of intellectual bankruptcy. Yet, with this issue, there actually does seem to be a slope. In every jurisdiction where it has been introduced euthanasia has spread to a much wider group of people than was intended. My mind was crystallised on this issue by the case in Belgium of the two twins who were deaf and had Usher syndrome and who were perfectly healthy but feared going blind and were granted euthanasia.[11]

2.14 In a paper Dr Christopher Ryan, a consultant psychiatrist, authored in the Australian and New Zealand Journal of Psychiatry, Dr Ryan was critical of the 'slippery slope' argument:

> The slippery slope arguments do not set out to show that there is anything intrinsically wrong with AVE, but rather maintain that the legalisation of AVE and its moral acceptance would inevitably lead to a deterioration of moral standards resulting in clearly unacceptable consequences. This deterioration is envisaged to take place in one of two ways. First, it may be that no logical distinction can be drawn between the allowable acts and the

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8 Catholic Women's League of Australia, *Submission 2*, p. 2. Professor Boer's warning of a slippery-slope was raised in *Submission 4*, Not Dead Yet UK; *Submission 8*, Evangelicals for Life; *Submission 19*, Salt Shakers; *Submission 27*, Anglican Diocese of Sydney; *Submission 30*, The Presbyterian Church of Tasmania; *Submission 52*, The Right to Life Australia Inc.; *Submission 53*, Dr David van Gend; *Submission 180*, HOPE: preventing euthanasia and assisted suicide; as well as a number of form letters received by the committee.

9 Mr Lyle Shelton, Australian Christian Lobby, *Proof Committee Hansard*, 3 October 2014, p. 60.

10 Mr Lyle Shelton, Australian Christian Lobby, *Proof Committee Hansard*, 3 October 2014, p. 60.

11 Mr Craig Wallace, Lives Worth Living, *Proof Committee Hansard*, 3 October 2014, pp. 18–19.

> unacceptable consequences. Second, even if a logical distinction can be found, the proponents of the slippery slope worry that society will not heed that distinction.
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> Psychological and social factors will, once unleashed, trample on the niceties of logical distinctions and the feared consequences will unfold. In its fiercest form the slippery slope argument sees the legalisation of AVE as the beginning of a malignant and fulminating social decay.[12]

2.15 Professor Margaret Otlowski concurred with this view that the slippery slope argument is not based on the 'inherent wrongfulness of the individual act, but rather, on the practical consequences of legislation' and informed the committee that the arguments put forward are 'completely unsubstantiated':

> The most commonly cited objection to the legalisation of active voluntary euthanasia is the 'slippery slope' argument: that the legalisation of active voluntary euthanasia would lead to widespread involuntary euthanasia and the termination of lives no longer considered socially useful. This is, however, a completely unsubstantiated argument. The 'slippery slope' argument is typically made without regard to the risks of abuse or other problems involved in *retaining* the present law.[13]

2.16 Dr Ryan, when asked of his views on the idea of voluntary euthanasia being introduced into the Netherlands, explained that the argument of the 'slippery slope' had, in his view, been disproven even though he did not consider the model used in the Netherlands to be an optimal approach:

> As I said, I am not a particular fan of the way that the Netherlands have constructed their access to the euthanasia regime. It has not been constructed in the way that we construct things. It is very much a European and particularly a Dutch way of doing it. I am sure the committee would know that, originally, it was not legislation; it was that you could kill your patient, but you would not be prosecuted if you did certain things. Those things were codified and then that was turned into legislation. I do not think the Netherlands is now a cesspool of people being killed willy-nilly, but I also do not think it has set things up as safely as it could have done. Oregon is a much better model. And I think an improved Oregon is an even better model.[14]

2.17 Professor Otlowski agreed with the view that the experience of the Netherlands 'debunks' the slippery slope argument:

> Certainly the Netherlands, for example, is a good model. I would suggest that it also debunks arguments about slippery slopes because there is now strong empirical evidence that, with such legislation in force, it can operate satisfactorily. There is a strong belief in the Netherlands that the majority of

12 Dr Christopher Ryan, Australian and New Zealand Journal of Psychiatry 1995; 29: 581.

13 Professor Margaret Otlowski, *Submission 56*, pp. 10–11.

14 Dr Christopher Ryan, *Proof Committee Hansard*, 3 October 2014, p. 16.

> cases are being openly reported now because doctors know that is the legal pathway.[15]

2.18 Christians Supporting Choice for Voluntary Euthanasia cited the Oregon experience as also supporting this view:

> From my understanding, in Oregon they have had this legislation for 17 years and they have done studies which have shown that this slippery slope you are referring to does not exist. It is a scaremongering tool used by those who are ideologically opposed to the proposed legislation and who will do anything they can to stop the law. We in Christians Supporting Choice side with loving compassion and mercy and not with religious dogmatic adherence to a particular point of view…There is no slippery slope.[16]

2.19 Mr Peter Short, appearing before the committee with a terminal diagnosis of oesophageal cancer, stated that in his view, '[t]he fact that people have coined a phrase for a key objection to the bill is to me both scary and demeaning', stating:

> Is it rational to take a position of denying the terminally ill and suffering the choice at the end of their life, because we are concerned we cannot put effective rules around a dying process? We manage road rules, alcohol rules and smoking rules. All are slippery slopes far more difficult and destructive, but all well-accepted in society and in law.[17]

2.20 Indeed, Dying with Dignity Victoria argued that a slippery slope was more likely to occur in an environment where voluntary euthanasia is prohibited rather than a society where a transparent, legislative framework regulates the occurrence.[18] This was a view shared by others,[19] including Professor Otlowski.[20]

The role of palliative care

2.21 Many submitters raised concerns that the introduction of voluntary euthanasia would undermine investment in, as well as the role and the value placed on palliative care:

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15 Professor Margaret Otlowski, University of Tasmania, *Proof Committee Hansard*, 15 October 2014, pp. 8–9.

16 Mr Geoffrey Williams, Christians Supporting Choice for Voluntary Euthanasia, *Proof Committee Hansard*, 3 October 2014, p. 38.

17 Mr Peter Short, *Proof Committee Hansard*, 3 October 2014, p. 30.

18 Ms Lesley Vick, President, Dying With Dignity Victoria, *Proof Committee Hansard*, 15 October 2014, p. 46.

19 See, SAVES, *Submission 3*, p. 1; Dying with Dignity NSW, *Submission 58*, p. 7; and Dr Rosemary Jones, *Submission 98*, p. 1.

20 Professor Margaret Otlowski, *Submission 56*, p. 11.

> There is also a danger that there would be reduced investment in improving palliative care by research and reduced need seen to increase the availability and access to palliative care.[21]

2.22 By contrast, Mr Peter Short, in sharing his experience with the committee explained how, in his view, the introduction of voluntary euthanasia would not undermine palliative care. Rather he suggested that it should be a part of the tool kit available in palliative care and medicine:

> [O]nly someone who is in my position can really understand this. People talk about the palliative process and people talk about the end as the last week or the last two weeks. I found out nine months ago I was going to die and at the start, straight away into the palliative process, fantastic people explained what I could expect. I explained that I wanted to die at home and went through those sorts of conversations and they explained that they would medicate me as needed and my doctors promised me that they would do everything in their power to ensure that I had as calm and as peaceful a death as possible.
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> …People talk about palliative care as being a last-minute process with the drugs and the nurses and things. My palliative care journey started when, as soon as I was diagnosed, the family was introduced to a psychiatrist: 'Go and have a talk and get your head straight. You're going to go off the planet or not.' Maybe I have!…And then they come around and they just check up on me as we go.
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> So the palliative care process, I think, is fantastic, and, the more we can invest in improving that, so be it. This is simply a tool that should be part of the palliative care process.[22]

2.23 Many submitters and those who gave evidence to the committee generally shared the view that there is a need for greater investment in palliative care and while many proponents of voluntary euthanasia see value in palliative care, they consider that euthanasia is required for those circumstances where even the best palliative care will not relieve the suffering or distress of a terminally ill patient.

2.24 For example, the South Australian Voluntary Euthanasia Society (SAVES) explained:

> It is widely acknowledged, including by Palliative Care Australia and the Australian Medical Association, that even the best of palliative care cannot help all patients – between 5-10% find their suffering so unbearable that they persistently request an assisted death. Our palliative and medical care is highly regarded, but it can never be 100% effective.[23]

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21 Mr Terri Kelleher, President, Australian Family Association, *Proof Committee Hansard*, 15 October 2014, p. 16. See also, Catholic Women's League of Victoria and Wagga Wagga, *Submission 7*, p. 1; and Knights of the Southern Cross, *Submission 11*, p. 1.

22 Mr Peter Short, *Proof Committee Hansard*, 15 October 2014, pp. 31–32.

23 South Australian Voluntary Euthanasia Society, *Submission 3*, p. 1.

2.25 Professor Roderick MacLeod, a palliative care specialist explained to the committee that in his experience, when people who are suffering ask for euthanasia what they are expressing is that they do not want to live as they currently are, and that in those circumstances:

> The skill of the palliative care team is to identify which of those elements can be readily dealt with and which will take time. Sometimes it is the physical elements which are the easiest to deal with and sometimes there are elements of suffering—so-called, which is why I have a difficulty with that concept—that cannot be relieved.[24]

2.26 Assistant Professor Andrew Cole, also a palliative care specialist, explained how the lack of training and experience in palliative care and medicine can cause suffering:

> There is a natural dying process that medical students are not taught well about. Dehydration is part of the natural dying process, and doctors often interfere with that and hydrate people unnecessarily and cause suffering. So dehydration, with the reduction of pain levels and so forth that goes with it, is not all bad.
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> …hastening times is not necessarily the way forward. Rather, it is providing care and support, letting the natural processes take their course and choosing to withdraw therapies that are not reasonable or not helpful. I spend a lot of time with older patients stopping unnecessary medications for hypertension and all the other things that are just causing side effects. That is a perfectly appropriate part of medical care because medications that do good in one situation do not necessarily do good in another situation.[25]

2.27 Professor Cole explained that in his father's experience, palliative care was available and able to provide a peaceful outcome for the family.[26]

Public opinion

2.28 The committee received hundreds of submissions in support of the Bill, many from older Australians expressing the desire to have control in how they die and many stating that their views were based on personal experience.

2.29 The committee heard also that public opinion is shifting and that more than 80 per cent of the population is in favour of voluntary euthanasia:

> Opinion polls in Australia consistently show strong support for a regime of voluntary assisted dying. Polls taken by a variety of polling organisations over the last ten years have registered rates of support at between 70% and 85%.[27]

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24 Professor Roderick MacLeod, *Proof Committee Hansard*, 15 October, p. 25.

25 Professor Andrew Cole, *Proof Committee Hansard*, 15 October 2014, p. 29.

26 Professor Andrew Cole, *Proof Committee Hansard*, 15 October 2014, p. 29.

27 Dying with Dignity NSW, *Submission 58*, p. 8. See also, Australian Sex Party, *Submission 62*, pp. 2–3; Christians Supporting Choice for Voluntary Euthanasia, *Submission 86*, p. 2.

2.30 Some submitters however questioned the legitimacy of these statistics.[28] Clearly, many who are opposed to voluntary euthanasia do so passionately and for deeply held moral, religious or practical reasons.

28 For example, see, Australian Family Association Western Australian Division, *Submission 60*, pp. [2–3]; Anglican Church Diocese of Sydney, *Submission 27*, p. 6; and the ACT Right to Life Association, *Submission 49*, p. 1.