A Peaceful and Gracious Death

Assisted suicide and **euthanasia** are topical concerns world-wide. In Australia, attempts are made regularly to reform the law, while in Europe and North America there is a movement toward the legalisation or decriminalisation of voluntary euthanasia and physician-assisted suicide. Euthanasia is illegal in all Australian states and territories and may result in a person being charged with murder, manslaughter or assisting suicide. Assisted suicide is illegal in all Australian states and territories except for Victoria. On 29 November 2017 the Victorian Legislative Assembly passed the **Voluntary Assisted Dying Act 2017**, which will legalise voluntary assisted dying (physician-assisted suicide) in Victoria from 19 June 2019.

Some Definitions

Euthanasia is a deliberate, intentional act of one person to end the life of another person in order to relieve that person's suffering. Euthanasia may be **voluntary**, when it is performed at the request of the person whose life is ended, **non-voluntary**, when the person whose life is ended is not competent, or **involuntary**, when it is performed upon a person who has not expressed a wish to die, or who has expressed a wish to continue living.

Assisted suicide (also known as **assisted dying**) occurs where a person intentionally kills him/herself with the assistance of another, who provides the knowledge or means to die. In assisted suicide, the act that causes death is performed by the person who dies him/herself.

The Current Situation

Although health professionals have a duty to provide life-sustaining treatments to patients under their care, this duty will not apply where the patient has capacity and refuses such treatment either at the time the treatment is offered or in an Advance Care Directive (see page 13), or where the treatment is considered by the doctor to be inappropriate in the circumstances. In these cases, the health professional is under no duty to provide the treatment even though the patient will die without it, and the patient is considered to have died naturally from their medical condition. The patient always has the right to refuse food and hydration, and a doctor who respects this right is not liable under law. In providing appropriate palliative care, a health professional is not performing euthanasia or assisted suicide where his/her intention is to relieve the patient's suffering, even though death may be hastened by the provision of such treatment.

Two Considerations

In evaluating legislation on this issue, two matters must be held in tension: the right of the individual to self-determination, and considerations of community well-being, i.e., the common good. The complexities of the arguments that pertain to this tension are very clearly and concisely outlined in the concluding section of the book 'Being Mortal' by Atul

Gawande.[1] Gawande writes, "At root, the debate is about what mistakes we fear most – the mistake of prolonging suffering or the mistake of shortening valued life"[2]

Arguments for assisted suicide often develop along the lines of "my body, my death, my choice." One post on Debate.Org reads:

> Bodily Autonomy: Just as we have the right to say no to someone who would like to use our body for their own purposes we also have the right to use our own body as we see fit, so long as it does not infringe on the autonomy of another. This includes the right to kill ourselves.[3]

However, Father Frank Brennan writes:

> It is questionable whether we have enough in our philosophical toolbox when dealing with difficult new social questions if the only instruments available are autonomy, human rights, and non-discrimination. All those involved at the table of public negotiation … are entitled to express scepticism about the adequate testing of any new proposal and to seek answers to the likely next steps should the proposal be implemented. They are also entitled to agitate the question whether the proposal is ethically sound according to the diverse ethical views held in the community.[4]

Our individual right to some measure of self-determination must be weighed in the balance with the needs of the community to which we belong. Arthur Dyck, professor of population Ethics at Harvard, writes:

> Does the kind of thinking that permits assisted suicide provide a moral basis for protecting the preciousness of human life, or does it fail to provide a moral structure that will predictably protect individual and communal life? What I will argue is that there is a moral structure that we share as human beings. …This same moral structure, for reasons I will later suggest, is the basis for laws against homicide, and does not support the legalization of assisted suicide. The rationale for assisted suicide sets aside this moral structure, substituting an account of moral agency that will not, in my view, predictably sustain individual and communal life, nor the laws against homicide and euthanasia.[5]

The Case for Assisted Suicide

At the heart of this debate lies a laudable concern for those who are experiencing severe pain or anguish as they move toward death.

In June 2017, the Age newspaper stated:

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[1] Atul Gawande, *Being Mortal: Illness, Medicine and What Matters in the End* (Great Britain: Profile Books, 2014), pp 243-245.

[2] Gawande, *Being Mortal,* 244.

[3] Debate.Org, 'Should terminally ill patients have the right to doctor-assisted suicide?' Accessed 22/04/18.

[4] Frank Brennan, *Maintaining a Convinced and Pondered Trust: The 2015 Gasson Lectures* (Adelaide: ATF Theology, 2015), 33-34.

[5] Arthur Dyck, *Life's Worth: The Case Against Assisted Suicide* (Grand Rapids: William B Eerdmans, 2002), 8.

> Here's the core of the case for change: there can be a crescendo of suffering as death draws nigh; a doctor's duty is to relieve suffering; some suffering will only be relieved by death; a doctor's duty is to respect a patient's autonomy; some patients rationally and persistently request assistance to die; palliative care cannot relieve all the pain and suffering of dying patients.[6]

A group of six well-known American philosophers, in a brief to the United States Supreme Court, declared:

> Each individual has the right to make the most intimate and personal choices central to personal dignity and autonomy. That right encompasses the right to exercise some control over the time and manner of one's death.[7]

Some who suffer from incurable terminal illnesses choose to commit suicide themselves. They are often forced to choose ugly ways of self-destruction that bring additional suffering to the loved ones they leave behind. Physician Assisted Suicide would remove this temptation. The provision of life-ending medication can also have another benefit. Michael Short makes the point:

> Perhaps the best reason for this is that while about a third of the terminally ill patients given the means to end their lives at a time of their choosing do not actually take that option, every single one who is provided the option immediately benefits. Simply having the means and knowledge provides profound palliation; it relieves fear and anxiety. [8]

The Spiritual Dimension of the Case for Assisted Suicide

Hans Kung, Roman Catholic priest and theologian, makes a case for assisted dying in his article, 'A Dignified Dying'. He suggests that behind the theological arguments against assisted dying stands a misguided view of God, the so-called 'argument from sovereignty'. He thus describes this erroneous image:

> God as the creator who simply exercises sovereign control over human beings, his servants; their unconditional Lord and owner, their absolute ruler, their law-giver, judge, and basically also executioner. But not God as the father of the weak, the suffering, the lost, who gives life to human beings and cares for them like a mother, the God of the covenant who shows solidarity, who wants to have human beings, in his image, as free responsible partners.[9]

He sets in place of this image the person and practices of Jesus, walking in whose footsteps, we should heal the sick and set about 'reducing and removing suffering as far as possible'[10]

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[6] Editorial, The Age newspaper, *The Gentle Case for Assisted Dying,* 17th June, 2017.

[7] Ronald Dworkin et al, "Brief of Ronald Dworkin, Thomas Nagle, Robert Nozick, John Rawls, Thomas Scanlon and Judith Jarvis Thomson as Amicus Curiae, in Support of Respondents," *Issues in Law and Medicine 15*, no. 2 (Fall 1999): 196.

[8] Michael Short, 'Why Australia Should Allow the Right to Physician Assisted Death,' *Sydney Morning Herald,* 22/03/16.

[9] Hans Kung, 'A Dignified Dying' in *On Moral Medicine: Theological Perspectives in Medical Ethics* (Grand Rapids: Eerdmans, 2012), 1090.

[10] Kung, 'Dignified Dying,' 1090.

He goes on to say that ‘With discipleship of Jesus goes an ethic of responsible shaping of life – from beginning to end.’[11] Kung speaks of the resistance that was aroused by the use of artificial birth control, a resistance which was based on the same argument of the sovereignty of God over life. Many who once opposed contraception, Kung suggests, now acknowledge that ‘God has made human beings responsible for the very beginnings of human life.’[12]

Kung points out that in the last century, medical science has succeeded in delaying death, which once was far more rapid, so that to the older phases of antenatal life, childhood, adolescence, adulthood and old age has been added another age, that of terminal illness or senility. These medical advances are not, he says, the result of nature, or of the will of God, but of humankind.[13] It is acceptable then for human beings to choose to complete the process of their own leave-taking from the world. He concludes:

> A dignified dying … includes responsibility for dying in keeping with human dignity – not out of a mistrust or arrogance toward God but out of unshakeable trust in God, who is not a sadist, but the merciful God, whose grace proves eternal.[14]

The Case Against Assisted Suicide

Those who oppose the legalisation of assisted suicide do so for a number of reasons.

1. **Legalising Physician Assisted Suicide (PAS) poses a threat to the weak and vulnerable in our society.**

Although in the Victorian legislation, only PAS is legalised, the links between PAS and euthanasia are strong. It makes little sense that only those who are capable of self-administering a lethal drug should be given the option. Those who are too disabled by illness to kill themselves may equally wish to do so. If the argument for PAS rests upon the notion of relieving severe pain or suffering, then euthanasia is a logical next step.

PAS will endanger the lives of the weak, the poor and the marginalised because of ‘the cultural pressures and economic incentives that will drive it.’[15] A report by the New York State Task Force on Life and the Law, explains:

> The Task Force members unanimously concluded that legalizing assisted suicide and euthanasia would pose profound risks to many patients.…
>
> … The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care.…
>
> … The clinical safeguards that have been proposed to prevent abuse and errors would not be realized in many cases.

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[11] Kung, ‘Dignified Dying,’ 1090.

[12] Kung, ‘Dignified Dying,’ 1092,

[13] Kung, ‘Dignified Dying,’ 1093.

[14] Kung, ‘Dignified Dying,’ 1096.

[15] Ryan Anderson, ‘Always Care, Never Kill: How Physician-Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality,’ *The Health Foundation Site,* March 24, 2015, accessed 12/04/18.

> We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine … to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill. They would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals … are likely to be extraordinary. [16]

2. **Legalising PAS will change the culture in which medicine is practised.**

The Hippocratic Oath declares:

> I will keep [the sick] from harm and injustice. I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect.[17]

The administration of PAS runs counter to the principle that has underpinned the practice of medicine for centuries. Medical professionals are being asked to use the tools of healing as techniques for killing. Dr Leon Cass, a medical doctor and former chairman of the President's Council on Bioethics protests:

> The legalization of physician-assisted suicide will pervert the medical profession by transforming the healer of human beings into a technical dispenser of death. For over two millennia the medical ethic, mindful that power to cure is also power to kill, has held as an inviolable rule, "Doctors must not kill."[18]

The Australian Medical Association (AMA) opposes assisted suicide and euthanasia. In a position statement, it declares: 'Doctors should not be involved in interventions that have as their primary intention the ending of a person's life'.[19]

Physician-assisted suicide will not only corrupt the professionals who practice medicine, but also affect the patients because it threatens to fundamentally distort the doctor–patient relationship, greatly reducing patients' trust of doctors and doctors' undivided commitment to the healing of their patients.

The risk of corruption does not apply only to doctors. PAS will also impact insurance providers and the financing of health care. Assisting a patient to commit suicide will often be a more cost-effective measure than actually caring for the patient. In fact, some advocates of PAS and euthanasia make the case on the basis of saving money. For example, Baroness Mary Warnock, a leading ethicist in the United Kingdom, has argued: "If you're demented, you're wasting people's lives—your family's lives—and you're wasting the resources of the National Health Service." Warnock goes on to suggest that such people have a "duty to

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[16] New York Department of Health Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, Preface - Executive Summary and Introduction, May 1994.

[17] Ludwig Edelstein, *The Hippocratic Oath: Text, Translation and Interpretation* (Baltimore, MD: Johns Hopkins University Press, 1943).

[18] Leon Kass, , "Dehumanization Triumphant," *First Things*, August 1996, https://www.firstthings.com/article/1996/08/dehumanization-triumphant Accessed 21/04/18.

[19] Australian Medical Association Position Statement, 'Euthanasia and Physician Assisted Suicide'. 2016. https://ama.com.au/system/tdf/documents/AMA%20Position%20Statement%20on%20Euthanasia%20and%20Physician%20Assisted%20Suicide%202016.pdf?file=1&type=node&id=45402 Accessed 18/04/18.

die."[20]

The founder of the Hemlock Society, Derek Humphry, also highlights the role of money, suggesting that "the pressures of cost containment provide impetus, whether openly acknowledged or not, for the practicalities of an assisted death."[21] He adds that "the connections between the right-to-die and the cost, value, and allocation of health care resources are part of the political debate, albeit frequently unspoken."[22] Humphry himself is willing to speak about the cost: "It is impossible to predict exactly how much money could be saved.… Conservative estimates, however, place the dollar amount in the tens of billions."[23]

3. Legalising PAS may compromise the family and intergenerational obligations.

In our societies, family has traditionally been the place where loving care is given. Human lives follow a cycle from helplessness in infancy, through caring for the vulnerable in adulthood, often toward some degree of dependency in old age. Throughout this progression, there will undoubtedly be times of difficulty when people need the assistance of others. The family has been a central social institution for resources to survive the challenges of life. Mothers and fathers take care of children at the beginning of life, and their children take care of aging parents as they draw toward the end.

Family life is meant to include some degree of mutual dependency. Ethicist Gilbert Meilaender explains why he refuses to accept the logic of rampant individualism:

> Is this not in large measure what it means to belong to a family: to burden each other—and to find, almost miraculously, that others are willing, even happy, to carry such burdens? Families would not have the significance they do for us if they did not, in fact, give us a claim upon each other. At least in this sphere of life we do not come together as autonomous individuals freely contracting with each other. We simply find ourselves thrown together and asked to share the burdens of life while learning to care for each other.[24]

The introduction of PAS has the potential to undermine familial relationships and endorse the view that sick and elderly relatives are not people to be loved but burdens to be coped with. Physician-assisted suicide would alter how people in general view the disabled and elderly and how the disabled and elderly view themselves. In the Annual Report produced each year by the Oregon State Public Health Division, a record is kept of the reasons why people have

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[20] Martin Beckford, "Baroness Warnock: Dementia Sufferers May Have a 'Duty to Die,'" *The Telegraph*, September 18, 2008.

[21] Derek Humphry, *Freedom to Die: People, Politics, and the Right-to-Die Movement* (New York: St. Martins, 2000), pp. 339

[22] Humphry, *Freedom to Die,* 340.

[23] Humphry, *Freedom to Die,* 353.

[24] Gilbert Meilaender, "I Want to Burden My Loved Ones," *First Things*, October 1991, http://www.firstthings.com/article/1991/10/003-i-want-to-burden-my-loved-ones Accessed January 28, 2015.

[25] No To Assisted Suicide Posted September 8, 2015 in News. Accessed 15/4/2018.

accessed assisted suicide. In 1998, when the Death with Dignity act came into effect, 13% of people applying for medication to end their lives did so because they were frightened of being a burden to their families. This figure has increased, until in 2012, 57.1% opted for assisted suicide for that reason. In Washington State, the figure for 2014 was 61%. This suggests that the so-called ‘right to die’ can become instead a duty to die, negating rather than supporting the autonomy of the individual.[25]

4. PAS presents a danger to some people in our society.

There are a number of subsections of Australian society for whom assisted suicide poses an additional threat. Among these groups are women, indigenous Australians and people with disabilities.

Women and Assisted Suicide

A leading motivation for the legalisation of assisted suicide in Victoria and New South Wales and throughout Australia is the autonomy of the patient. However, research suggests that “gendered risks” [26] may hinder women’s quest for autonomy in end-of-life decisions, making them uniquely vulnerable to assisted suicide laws.

While eligibility under the Victorian and NSW bills requires that a patient must be suffering from a terminal illness from which they will be likely to die in 12 months, the concern for women is that the final decision to end their lives may nevertheless be influenced by risk factors that contest the notion of choice. These “gendered risks” include:

Longer life span - women tend to live longer than men and are thus more likely to develop diseases and disabling conditions or experience elder abuse and discrimination. All of these can motivate the desire for assisted suicide. The report on elder abuse by the Australian Law Reform Commission claims that women are significantly more likely to be victims than men, and that the rate of neglect of older women could be as high as 20%.[27]

Greater likelihood of experiencing the death of their partners - Due to their relative longevity, many women experience the death of a partner or spouse and enter into old age without this support and companionship. A 2013 Australian study found that living alone is an important predictor of suicide in older adults.

Fewer economic resources in old age – In old age, women tend to have fewer economic resources. This economic disadvantage limits their care options and leaves them open to financial pressures and difficulties. In addition, women are also more likely to have to pay for care than men, since male partners and families are less likely to care for them.

A general tendency to be more self-sacrificial and less assertive - Women are arguably more self-sacrificial and less assertive than men, whether by nature, by socialisation or simply in terms of society’s ideals about femaleness. George comments on ‘cultural influences that

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[26] Katrina George, ‘A Woman’s Choice? The Gendered Risks of Voluntary Euthanasia and Physician-Assisted Suicide,’ *Medical Law Review* 15, Spring 2007, pp. 1-33. This section on the ‘gendered risks’ for women choosing assisted suicide is indebted to this article and the research it cites.

[27] George, ‘A Woman’s Choice?’, 9-11.

idealise femininity in terms of self-effacement and self-sacrifice.'[28] Women may therefore be more likely to request assisted suicide to spare those they love the burden of looking after them, or to feel unworthy of their family's time and financial resources. The friend of one woman who opted for assisted suicide said of her: 'She felt it was a gift to her family, sparing them the burden of taking care of her'.[29]

A preference for passive suicide methods – Many women prefer structured and passive methods of suicide, with the result that the rate of assisted death in places where PAS has been legalised is almost four times as high as the usual female suicide rate.

A greater tendency to suffer from psychological problems such as depression: Because they are more prone to depression and other psychological problems than men are, women are more likely to attempt suicide. Mental illness does not qualify people for assisted suicide under the Victorian and NSW bills, but does not disqualify them either. Conditions such as depression, which is treatable, should not form the basis of a decision to die.

The evidence of entrenched patterns of violence against women in Australian society: Female assisted suicide needs to be considered in light of pervasive male violence against women. Research indicates striking similarities between the broader patterns of male violence against women and at least one type of assisted death: the so-called 'mercy killing'[30]. George states:

> [M]ercy killings are characterised by the same themes of domination, possessiveness and control which animate other killings of women by men. Usually, there is no consent from the female victims. There is no research which points to similar correlations with euthanasia and physician-assisted suicide. Nonetheless, these insights must challenge the theory that women who decide for euthanasia and physician-assisted suicide are always exercising autonomy.[31]

The prevalence of violence against women in Australia, (particularly domestic violence carried out by a spouse or partner) is a serious problem, and we should understand that the dynamics underlying other forms of gendered violence that result in the deaths of women may sometimes also underlie female assisted suicide. These insights challenge the presumption that women who decide for assisted suicide are invariably exercising autonomy. Legalisation could compound oppressive sociocultural influences and facilitate the last of many non-choices for some women.

Indigenous Australians and Assisted Suicide

In the context of discussion of the legislation regarding voluntary euthanasia in the Northern Territory, Jennifer Fitzgerald writes:

> Although 22% of the Northern Territory population are indigenous Australians, their identity was largely ignored in the debate leading up to the enactment of the *Rights of the Terminally Ill Act* 1995 (NT). Indeed, it was not until after the legislation was

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[28] George, 'A Woman's Choice?', 18.

[29] S.S. Canetto and J.D. Hollenshead, 'Older Women and Mercy Killing' (2000–2001), 180.

[30] See George, 'A Woman's Choice?' pp 11–18.

[31] George, 'A Woman's Choice?', 18.

> enacted and an education programme undertaken to *inform* Aboriginal people of the nature and content of the legislation that their concerns and views began to be heard.[32]

Chips Mackinolty, who undertook that education programme in the Northern Territory, argues that:

> [T]he 'debate' over euthanasia legislation has not come to grips with the reality of the jurisdiction in which it has been enacted - one in which such a high percentage of the population has such a radically different world view from the general population. The 'debate' has concerned itself entirely with either Western ethical/moral arguments, or arguments of the 'rights' of the Northern Territory to make legislation for itself without interference from the Commonwealth . . . Both lines of argument centre solely on a Western world view; both ignore Aboriginal world views.[33]

Many indigenous Australians who already feel distrustful of medicine as practised by non-indigenous doctors would feel even less inclined to put themselves into the care of doctors who have the legal right to kill.

People with Disabilities and Assisted Suicide

Many people with disabilities oppose assisted suicide legislation on a number of grounds.

a. The concept of dignity, as expressed in phrases such as 'dying with dignity,' is often used to express the idea of being able to do personal acts of self-care oneself. Some people who are suffering from debilitating illnesses reach a stage where such independent self-care is compromised and request to be allowed to 'die with dignity.' Since many people with disabilities need assistance in such personal aspects of daily living, this notion suggests that their lives are without dignity. Diane Coleman, president of Not Dead Yet, claims:

> The primary underlying practical basis for the physician's determination that the individual is eligible for assisted suicide is the individual's disabilities and physical dependence on others for everyday needs, which is viewed as depriving them of what nondisabled people often associate with "autonomy" and "dignity," and may also lead them to feel like a "burden." …Disability groups, however, disagree that needing help in dressing, bathing, and other intimate daily tasks robs a person of dignity.[34]

b. It is difficult for people with disabilities to continue to perceive their lives as valuable and worthwhile when they find that people who suffer from the same or similar conditions are considered suitable candidates for assisted suicide or euthanasia. Alison Davis, a UK-based disability rights campaigner, and national coordinator of UK disability rights organisation No Less Human, writes:

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[32] Chips Mackinolty, 'Right Legislation: Wrong Jurisdiction?' 22(2) *Alternative Law Journal,* (1997) 68.

[33] Mackinolty, 'Right Legislation,' 71.

[34] Diane Coleman, 'Assisted Suicide Laws Create Discriminatory Double Standard,' *Disability and Health Journal* vol 3, issue 1, Pages 39–50, January 2010, accessed 21/04/18 .

> [I]n July 2005 Dutch paediatricians adopted as national guidelines a protocol from Groningen University Hospital allowing for the so-called “mercy killing” of newborn disabled babies, who clearly can’t volunteer. Most of these babies have spina bifida, which is one of the disabilities I have.[35]

c. Many disabled people are understandably fearful that their right to continued life will be compromised by those who do not perceive their lives to be worthwhile. This is especially true when they are undergoing medical treatment. Ben Mattlin, a freelance journalist based in Los Angeles, explains:

> It's been nearly 10 years since I was rushed to the hospital at 4 am, but you don't forget something like that. …
> All I remember is passing out in a hospital bed. My wife says I called out for my mother, who died in 1981. It looked like I was going to join her. …In context, I was lucky: I was in a well-equipped, big-city medical center. I was quickly surrounded by medical staff. But there was a delay. "Is he full code?" someone needed to know. … A rough translation: Should the hospital proceed with lifesaving surgery, or was I DNR? Meaning: Do not resuscitate. Fortunately, my wife was clear about my desire to live. We'd discussed this possibility before. And, in time, I made a full recovery. But not everyone has a significant other like mine. What happens to them?[36]

5. **Legalising PAS will expose Australians to abuses of the legislation.**

In 2001 the Netherlands legalised euthanasia and assisted suicide. Safeguards were put in place, and five regional committees were appointed, to assess whether each death met the criteria set by the legislation. For the first five years, the numbers of people accessing PAS and euthanasia remained low. Theo Boer, professor of ethics at the Protestant Theological University at Groningen, wrote in 2007 that ‘there doesn’t need to be a slippery slope when it comes to euthanasia. A good euthanasia law, in combination with the euthanasia review procedure, provides the warrants for a stable and relatively low number of euthanasia.’[37] From 2008, however, the numbers began to escalate at a rate of 15% per year. In 2012, 4,088 cases were recorded, in comparison with the 2002 figure of 1,882. Over time, the safeguards proved to be inadequate. Looking critically at countries in Europe where euthanasia is legal, Anderson claims:

> The evidence from these jurisdictions, particularly the Netherlands, which has over 30 years of experience, suggests that safeguards to ensure effective control have proved inadequate. In the Netherlands, several official, government-sponsored surveys have disclosed both that in thousands of cases doctors have intentionally administered

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[35] Alison Davies, ‘Euthanasia: The Death of Disability Rights’ *Australian Family Association Journal,* Vol. 31 No 3, 2010.

[36] Ben Mattlin, ‘People with disabilities often fear they’re a burden. That’s why legal assisted suicide scares me,’ *Vox ‘First Person’* website, 2017. Accessed 21/04/18.

[37] Theo Boer, *I supported our euthanasia law, but I was terribly wrong,* https://www.lifesitenews.com/opinion/i-supported-our-euthanasia-law-but-i-was-terribly-wrong-dutch-ethicist July 16, 2014.

> lethal injections to patients without a request and that in thousands of cases they have failed to report cases to the authorities.[38]

Kass declares:

> Physician-assisted suicide, once legal, will not stay confined to the terminally ill and mentally competent who freely and knowingly elect it for themselves. Requests will be engineered and choices manipulated by those who control the information, and, manipulation aside, many elderly and incurable people will experience a right to choose death as their duty to do so. Moreover, the vast majority of those who are said to 'merit' 'a humane and dignified death' do not fall in this category and cannot request it for themselves. Persons with mental illness or Alzheimer's disease, deformed infants, and retarded or dying children would thus be denied our new humane 'aid-in-dying.' But not to worry. The lawyers, encouraged by the cost-containers, will sue to rectify this inequity. Why, they will argue, should the comatose or the demented be denied a right to assisted suicide just because they cannot claim it for themselves? With court-appointed proxy consentors, we will quickly erase the distinction between the right to choose one's own death and the right to request someone else's.[39]

Theo Boer has reluctantly admitted that legislation to legalise PAS and euthanasia has been a mistake. He concludes:

> I used to be a supporter of legislation. But now, with twelve years of experience, I take a different view. At the very least, wait for an honest and intellectually satisfying analysis of the reasons behind the explosive increase in the numbers. Is it because the law should have had better safeguards? Or is it because the mere existence of such a law is an invitation to see assisted suicide and euthanasia as a normality instead of a last resort? Before those questions are answered, don't go there. Once the genie is out of the bottle, it is not likely to ever go back in again.[40]

The Netherlands are not the only place where abuses are alleged to have taken place. Belgium, Switzerland and Oregon, the places where some form of assisted dying or euthanasia have been legal for some years, have also been the subjects of such allegations.

The Spiritual Dimension of the Case Against Assisted Suicide

The belief in the sanctity of human life is a cornerstone of our civilisation, and of our system of justice. Anderson states:

> PAS's most profound injustice is that it violates human dignity and denies equality before the law. Every human being has intrinsic dignity and immeasurable worth. For our legal system to be coherent and just, the law must respect this dignity in everyone. It does so by taking all reasonable steps to prevent the innocent, of any age or condition, from being devalued and killed. Classifying a subgroup of people as legally eligible to be killed violates our nation's commitment to equality before the law—

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[38] Anderson, 'Always Care.'

[39] Kass, "Dehumanization Triumphant."

[40] Boer, 'I Supported our Euthanasia Law.'

> showing profound disrespect for and callousness to those who will be judged to have lives no longer “worth living,” not least the frail elderly, the demented, and the disabled. No natural right to PAS exists, and arguments for such a right are incoherent: A legal system that allows assisted suicide abandons the natural right to life of all its citizens.[41]

For Christians, as for people of many other faiths, human life is sacred. Christians derive this belief from three elements of their tradition. The first is the understanding that human beings are created in the image of God, as expressed in Genesis 1:27. Darrel Amundsen claims:

> The Christian concept of the imago Dei provided both the basis and the structure of the idea of inalienable rights and intrinsic human values that has prevailed in Western society until the present.[42]

The second is the incarnation of Jesus. Karl Barth declares that ‘the respect of life which becomes a command in the recognition of the union of God with humanity in Jesus Christ has an incomparable power and width.’[43]

The third element of the Christian tradition that affirms the absolute and immutable value of human life is the death and resurrection of Jesus. Anderson asserts:

> Surely the Christian belief in the resurrection puts the worth of individual human life beyond all calculation. At the same time, the belief in the resurrection puts the extent of God’s love beyond all calculation. In choosing to follow the resurrected Christ, Christians choose life, not death, in this life, and in the life to come.[44]

Palliative Care

Palliative Care has as its objective the ideal of quality care at the end of life for all. Palliative Care is care that helps people live their life as fully and as comfortably as possible when living with a life-limiting or terminal illness.

The Palliative Care Australia website thus outlines the services provided by Palliative Care:

> Palliative care identifies and treats symptoms which may be physical, emotional, spiritual or social. Because palliative care is based on individual needs, the services offered will differ but may include:

- Relief of pain and other symptoms e.g. vomiting, shortness of breath
- Resources such as equipment needed to aid care at home
- Assistance for families to come together to talk about sensitive issues
- Links to other services such as home help and financial support
- Support for people to meet cultural obligations
- Support for emotional, social and spiritual concerns
- Counselling and grief support
- Referrals to respite care services

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[41] Anderson, ‘Always Care,’ accessed 12/04/14.

[42] Darrel Amundsen, *Medicine, Society and Faith in the Ancient and Medieval Worlds* (Baltimore: John Hopkins University Press, 1996), quoted in Dyck, *Life’s Worth,* 75.

[43] Karl Barth, *Church Dogmatics III/4* trans A. Mackay et al (Edinburgh: T& T Clark, 1961), 339.

[44] Dyck, *Life’s Worth,* 84.

> Palliative care is a family-centred model of care, meaning that family and carers can receive practical and emotional support.[45]

The highly trained and experienced providers of Palliative Care can remove many of the discomforts and fears of those suffering from terminal illnesses.

Advanced Care Directives

An Advance Care Directive is sometimes known as a living will. It is composed by the individual concerned him/herself and is a written record of preferences for future care. The Directive can record his/her values, life goals and preferred outcomes, or directions about care and treatments. Advance Care Directives can also formally appoint a substitute decision-maker. An Advance Care Directive allows individuals who are unable to communicate to refuse or withdraw medical treatment. It does not give them the right to request euthanasia.

Advance Care Directives differ between states and territories. In every state of Australia, however, they have legal status, and health care professionals are obliged to comply with them. Some states have added conditions. In Northern Territory, the Advanced Care Directive can in some cases be over-ruled by a court of law. In Queensland, a number of conditions must be met before life-sustaining medication can be withdrawn. In Victoria and Western Australia, the Advance Care Directive no longer stands if the condition of the person concerned changes so that it is no longer relevant. With these few qualifying provisions, the intention of the individual as recorded in an Advanced Care Directive must be regarded as binding in all states of Australia. (To read about Advanced Care Directives, see footnote[46]).

Conclusion

The issue of assisted suicide is therefore many-facetted and complex. Those who fulfil the criteria for accessing assisted dying and wish to avail themselves of it are few in number, and their needs must be weighed against the possibility of harm resulting to many other vulnerable people. The need for the autonomy of the individual must be weighed against considerations of the common good.

As Gawande observes, “Our ultimate goal, after all, is not a good death but a good life to the very end.”[47] Nonetheless, in the act of dying itself, we express something of who we are and how we have lived. Some people chose to die at home, surrounded by family and friends. Some chose to die in hospital. The last days of our lives can be a time for goodbyes, for reconciliation, for thankfulness, or for the expression of regrets. In spite of the many problems associated with the shutdown of bodily functions, it is still possible, with the help of skilled practitioners, for us to die a gracious and peaceful death.

A number of services are available to assist in attaining this end. Hospital chaplains and pastoral carers can support not only the patient but their families and friends. Palliative Care provides both practical and psychological support until the time of death and for the families,

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[45] Palliative Care Australia Website, *‘What is Palliative Care?’*, *palliativecare.org.au/,* accessed 18/07/18.

[46] To access information about Care Directives see www.health.nsw.gov.au/patients/acp/Publications/acd-form-info-book.pdf for NSW and *https://www.advancecareplanning.org.au/resources/advance-care-planning-for.../act* for ACT.

[47] Gawande, *Being Mortal,* 245.

in the period after the death of the patient. Advanced Care Directives can be a source of comfort as patients know that their intentions have been recorded. When they can no longer express their wishes, families have the assurance that they are making the right choices on their behalf. All of these provisions can remove many, if not all, the fears about end-of-life care that drive some individuals to consider PAS, whilst avoiding all the difficulties that arise from the misuse of euthanasia and PAS.

As Christians we affirm that human life is sacred and believe that all are made in the image of God. Our faith challenges notions of privileged status for the rich and powerful and demands equity for the poor, disabled, sick, vulnerable, and imprisoned. In our focus on a peaceful and gracious death, we are mindful of the numerous people who suffer around the world due to poverty, inequality and a lack of access to basic necessities of water, adequate food, sanitation and health care. In faith, we are committed to seeking a peaceful and gracious life and death for all.

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