

**Hunter Bible Church**  
**Big Ideas Night, Thursday May 10, 2018**

**Euthanasia and Assisted Dying: the Law and Why it should not change**

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## 1. Introduction

It is very easy for the media to generate a high degree of sympathy for a person who is suffering- we can all imagine ourselves in pain and know that we would like it to stop. Hence it is not hard to make a media-friendly case for assisting people to die- because that can seem like the only relief from pain. This can easily shade over into, not that I want relief from intolerable pain, but “my time has come to die” because I am tired of what life feels like. For example, this last week we have seen numerous media reports about a 104-year-old respected professor who is flying out to Switzerland to receive a lethal injection.<sup>2</sup> Apart from the astonishing longevity of this bloke, perhaps the most interesting part of the story is that he doesn’t seem to have any terminal disease (except the terminal condition we all suffer from, “life”.) The article suggests he has problems now coping on his own and he just wants to end it all.

Other people tonight will point out why this is, from a Christian point of view, a morally unacceptable option. We are all being made in God’s image, our lives are immensely valuable, and we all have a role to play in life that God has given us. We don’t have authority to lay down those lives until God chooses to take them away. Suicide is always a bad idea; and what we are talking about tonight, which goes sometimes under different euphemisms, sometimes needs to be bluntly named for what it is.

What I would like to do, briefly, is to set out some terminology which I think we need to get right, to outline the legal situation around Australia at the moment (but to notice very briefly some of the legal options elsewhere around the world), and to suggest a number of reasons why as a society we should not be introducing legislation that either allows or requires medical professionals to actively seek to end the life of their patients; nor should we allow laws authorising people to end their own lives.

I should say up front that I have benefited greatly in preparing this paper from some papers listed at the end. If you are interested in doing some more work on this area, I would encourage you to get hold of those excellent papers.

## 2. Definitions

It’s very important to use language clearly in this area, as it is easy to “slide” in discussions from an example of a case which is morally right, over to cases which seem to be morally wrong. Let me offer some definitions, and then talk about what I am *not* discussing.

### a. Euthanasia

The word “euthanasia” according to the Oxford English Dictionary is derived from:

Greek *εὐθανασία*, < *εὐ-* (see *eu- comb. form*) + *θάνατος* death.

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<sup>1</sup> Associate Professor in Law, Newcastle Law School, NSW; the views expressed here are, of course, my own and cannot be attributed to my institution.

<sup>2</sup> See <http://www.abc.net.au/news/2018-05-05/david-goodall-trip-to-switzerland-for-voluntary-euthanasia/9716354> .

The prefix “*eu*”, at least in many related contexts, means “well” or “good” – so a “eulogy”, for example, combines “*eu*” with “*logos*” for “word”, to mean “good words” (usually ones that are said on the occasion of a person’s death). The word “*thanatos*” means “death” (and for Marvel comics and movie fans, there is a connection with the name of the villain in the last Marvel movie, Thanos, who is a lover of death!)

In this context, then, “euthanasia” is referring to a “good death”. But what do we mean by this? Death is hardly ever a good thing! The word has come to mean, “death without undue pain”, but even here there are ambiguities.

Let me start by saying that it is a misuse of the word, in my view, to use it to refer to a situation where someone is so sick that they are going to die very soon, and a doctor may prescribe pain-relief measures which may incidentally lead to the person dying sooner than they would if the pain relief had not been supplied. Nor is it appropriate to use the term to refer to a decision not to use “heroic” measures to keep a person’s body functioning when it is clear that their other functions have failed; in those circumstances provision of nutrition is warranted but a decision to not supply drugs seems justified.

To quote Ahdar:

*Withdrawal of treatment* means the cessation of treatment considered to be futile and burdensome. This is not euthanasia. Some commentators speak of active versus passive euthanasia, but the distinction is misleading and unhelpful. Euthanasia is necessarily “active, since it needs the administration of lethal medication”.<sup>3</sup>

However, “euthanasia” is a word that is best used when a person’s death is the *aim* of a physician’s action; not when “allowed to happen” by withdrawal of other drugs, but rather where there is a positive act designed to cause a person’s death. One definition adopted in a few sources is this:

Euthanasia is the act of intentionally, knowingly and directly causing the death of a patient, at the request of the patient with the intention of relieving intractable suffering. If someone other than the person who dies performs the last act, euthanasia has occurred.<sup>4</sup>

We could even be blunter here, as Ahdar is, and refer to this as “doctor–assisted suicide” (DAS) where the person providing the means, and performing the last act, is a medical practitioner. Note that while the definition I have given above refers to “intractable suffering”, we will see below that this is a lot rarer than is usually supposed; and there is of course now social pressure to allow dying even when “suffering” in the usual sense of physical pain is not present.

### b. Assisted Dying

The concept of “assisted dying” is different again. This is a term that is best used to refer to a situation where the law allows the supply of drugs or other means to a person who wishes to take their own life. In other words, here we are clearly dealing with suicide, the intentional taking of one’s own life, and the circumstances in which a medical practitioner may assist that activity.

<sup>3</sup> Ahdar, at 461. See also his helpful discussion of the “double effect” principle and the moral status of withdrawal of futile medical assistance from a patient, at pp 465–470.

<sup>4</sup> Australian and New Zealand Society of Palliative Medicine Inc, “Position Statement: The Practice of Euthanasia and Assisted Suicide” (approved 31 Oct 2013 reviewed October 2016) accessible at <http://palliativecarewa.asn.au/site/wp-content/uploads/2014/03/ANZSPM-Position-Statement-on-Euthanasiaand-Assisted-Suicide.pdf>, cited in Quinlan at 3. See also Ahdar at 460.

### 3. Current and proposed law around these areas

What is the current law in this area? It is fairly straightforward. In general, to deliberately cause the death of another person is unlawful, whether done with a bad or a “good” motive.<sup>5</sup> It will often constitute the crime of murder.

In terms of causing one’s own death, suicide is not these days a crime.<sup>6</sup> But it is still a criminal offence to *assist* in a suicide.<sup>7</sup>

Quinlan comments:

Voluntary assisted dying has always been illegal in most parts of the world. It is now lawful in a small number of US States and European countries. In Australia, in legislation which has yet to become operative, it was legalised last year in Victoria. Apart from a brief period in the Northern Territory voluntary assisted dying has always [previously] been illegal in Australia. Voluntary Euthanasia was legal in the Northern Territory for less than 9 months (1 July 1996 to 25 March 1997) during the operation of the *Rights of the Terminally Ill Act* 1995 (NT) (the NT Act) prior to the Commonwealth Parliament overriding its operation by amendments to the *Northern Territory (Self Government) Act* 1978 (NT).<sup>8</sup>

In an academic paper, Quinlan summarises the legal position around the world in more details as follows:

Euthanasia was not recognised as medical treatment for 2,400 years: Margaret Somerville, *Bird on an Ethics Wire* (Mc-Gill Queen’s University Press, 2015), 166. It is however now permitted in the Netherlands, Belgium and Luxembourg. Doctor assisted suicide, in which a doctor provides the means of death to a patient, is permitted in the Netherlands and Luxembourg and in the US States of Oregon, Washington, Montana, Vermont and (since 5 October 2015) California. Assisted suicide (which need not involve a doctor) is permitted in Switzerland: see Jose Pereira, “Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls,” *Current Oncology* 18 (2011): 2, esp. 38. Euthanasia and doctor assisted suicide (together called physician assisted death or PAD) are now permitted in Canada following the Supreme Court of Canada’s decision in *Carter v Canada* [2015] 1 S.C.R. 331 (Can). For discussion of the Canadian position see College of Physicians and Surgeons of Ontario, Policy Statement #1-16 “Interim Guidance on Physician - Assisted Death 2. <http://eol.law.dal.ca/wp-content/uploads/2016/05/ON-MAID-Guidelines.pdf><sup>9</sup>

The Victorian legislation mentioned above is the *Voluntary Assisted Dying Act* 2017 (Vic), which passed the Victorian Parliament on 31 October 2017, and is due to commence on 19 June 2019.

There is a summary of the legislation on the ABC website which seems fair:

- Voluntary assisted dying will only be available to Victorians who are over the age of 18 and are capable of making decisions.
- They must be suffering from an incurable illness, which causes intolerable suffering, and be expected to live for less than six months.
- Mental illness and disability alone are not grounds for access to assisted dying, but people who meet the criteria and also have a mental illness or disability will not be denied access.
- Two doctors will have to sign off on the process, assessing whether the patient is eligible.

<sup>5</sup> I am leaving aside for the moment those very rare cases where the law may allow the intentional killing of another- a soldier in war, for example, or someone defending themselves or others against a violent attack where the death of the attacker seems the only way to stop the attack.

<sup>6</sup> See s 31A *Crimes Act* 1900 (NSW).

<sup>7</sup> See s 31C *Crimes Act* 1900 (NSW). For a conviction (in that case of the offence of manslaughter) of a family member for administering a lethal drug to a dying partner, see *R v Shirley Justins* [2008] NSWSC 1194 (12 November 2008).

<sup>8</sup> Quinlan, submission to *End of Life Choices in the ACT* Inquiry, Submission Number: 368; date authorised for Publication: 19/4/18.

<sup>9</sup> Quinlan, “Such is Life”, p 1 at n 5.

- A doctor is not allowed to initiate discussion or suggest voluntary assisted dying to a patient.
- A patient requesting a medically assisted death will have to make two formal requests as well as a written statement.
- The doctor will prescribe the substance, which will be dispensed by a pharmacist.
- If they are able, the patient will administer the lethal substance themselves, but if they are not, a doctor will be able to assist.
- The patient would have to nominate a contact person to return any unused substance to the pharmacist.
- Doctors will have the right to refuse to provide information, prescribe or administer an assisted-dying substance if they are conscientious objectors.<sup>10</sup>

In many ways it might be said that this legislation comes close to being the best that such legislation can be- there are a number of processes put in place to avoid some of the worst dangers, and one good feature is that it explicitly recognises the right of medical practitioners to conscientiously object and not be required to be involved- see s 7.

However, there are still a number of fundamental flaws with the Act, and I want to summarise briefly why I, and a number of other commentators in this area, think that the whole notion of authorising people to cause their own death, or authorising medical practitioners to actively cause their death, is a bad idea.<sup>11</sup> Based on past experience, it seems likely that proposals for such a law will be made in NSW in the near future.

#### 4. Reasons why legislation allowing assisted dying is a bad idea

There are a number of reasons why this sort of legislation is not good. I am summarising here some of the more detailed discussion in the articles noted at the end of the paper.

##### (a) No need to choose between assisted dying or unendurable pain

First, there is no need to choose between assisted dying or unendurable pain, as if these were the only two options. The plain fact is that the discipline of palliative care, and the technology around pain relief, have advanced a great deal in the last few decades. Quinlan comments:

No one should have to endure pain but the response to pain should be pain relief not death. The ability to control pain is substantially better in contemporary society than it has historically been, so for this to be a basis for voluntary assisted dying today when it has not been accepted for the vast bulk of human history as a justification is difficult to reconcile. Professor Margaret Somerville, Dr Brian Pollard and others have noted that pain control has been available to deal with pain across a wide spectrum of diseases for decades but that most doctors are poorly educated in the area. In her book *Death Talk* Somerville tells the story of her own father's death. She was telephoned and told that her father was in his final days. On arrival she found him in great pain and incoherent. She insisted on his being seen by a pain specialist. Following a change to his pain relief his lucidity returned and he lived almost pain free for a further nine months.

This of course is one anecdote, but of course single anecdotes are the regular focus of the case for assisted dying. The issue is not whether one can find examples of people whose pain has been better, or worse, managed, but what is the evidence of the overall trend? It seems clear that the overall trend is that management of severe pain is almost always possible today.<sup>12</sup>

<sup>10</sup> See <http://www.abc.net.au/news/2017-11-22/euthanasia-in-victoria-how-assisted-dying-laws-will-work/9115210> (29 Nov 2017)

<sup>11</sup> For a cogent summary of these, specifically in response to the Victorian legislation, see M Sneddon and S Kennedy "The unknowns of assisted dying" *The Spectator*, 24 Nov 2017, at <https://www.spectator.com.au/2017/11/the-unknowns-of-assisted-dying/>.

<sup>12</sup> See also Ahdar, 2016, at pp 497-500, offering a review of recent literature.

Dr Megan Best, who herself is a doctor with much experience in palliative care, comments in her 2017 article:

By now, we all know that palliative care provides multidisciplinary support for those at the end of life, but we may not be aware that most deaths are peaceful. Very few people should be in pain at the end of life, but sadly more than necessary are in this situation because palliative care funding is insufficient for our needs. Not all doctors are trained in palliative care. This situation is at risk of getting worse with aging of the population and increased demand on services. Commentators have noted that, even if assisted dying is legalised, it will not ease most suffering at the end of life. It is a distraction from the need to improve healthcare for the dying.<sup>13</sup> More access to palliative care is needed, as pointed out in the recent NSW Attorney General's report on palliative care provision.<sup>14</sup>

### (b) Parallels with Capital Punishment

For the Christian, one of the strongest arguments against assisted dying is the inestimable value of human life. But this can be appreciated from the perspective of the secular world when we consider, for example, the arguments that are regularly made against capital punishment. The focus of Professor Quinlan's argument in his 2016 article is to show how the major arguments that are used against capital punishment for crime (a position accepted by most commentators today, especially those from the more "progressive" end of politics), are almost exactly the arguments that show why euthanasia and assisted dying should not be authorised by law.

The following table may help to see the parallels in the arguments.

Argument	Why this is a reason to oppose capital punishment	Why this is equally a good reason to oppose euthanasia
The irrevocable nature of death	We cannot retract the death penalty; but we know there are cases where mistakes have been made and innocent people killed. Even a small risk that this might happen should not be tolerated.	We know there are many cases where someone expressed a wish at one point for their life to end, but they changed their mind when given proper care. Too quick a decision to administer euthanasia would be irrevocable. In overseas jurisdictions there is clear evidence that mistakes in application of criteria have been made leading to involuntary killing.
Risk to minority and vulnerable groups	"[C]apital punishment is ... disproportionately enforced against vulnerable groups such as those suffering from mental illness, the less educated, racial minorities and members of lower socio-economic groups." <sup>15</sup>	The elderly and the ill are incredibly vulnerable to pressure from family members (whether spoken or unspoken) and even to their own desire not to be a "burden", and so may end up being pressured into euthanasia.
Pain and suffering	Science cannot produce a guaranteed painless method of execution. Executions regularly "go wrong".	Despite promises of a quick and painless end, there are many examples where the technical process has gone wrong. "Every medical procedure can have complications. According to the research, technical problems and complications occur in up to 25% of cases of physician-assisted suicide". <sup>16</sup>
Bad effect on the ethos of the medical profession	It is wrong to require doctors to assist in executions, their job is to preserve life not take it.	It is wrong to require or even encourage doctors to assist in euthanasia. "Euthanasia and assisted

<sup>13</sup> Ezekiel Emanuel, 'Euthanasia and physician-assisted suicide: focus on the data'. *Medical Journal of Australia* 206(8), 2017, pp339-340.

<sup>14</sup> Giselle Wakatama, 'NSW palliative care the subject of scathing auditor-general report'. ABC News, 17 August 2017.

<sup>15</sup> Quinlan, 2016, at 13.

<sup>16</sup> Best, 2017, near n 24.

		killing contravene centuries of medical ethics that have prohibited such practices. In the words of the Hippocratic Oath, ‘Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course’. First, do no harm.” <sup>17</sup>
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### (c) Voluntary Dying always affects other persons

It is very clear that a decision to commit suicide, even when labelled “assisted dying”, is something that will always affect others, and is never an isolated event. The broadest sense in which this is true is that human beings are designed to, and do, live in community. We live in families, households and neighbourhoods, we work and play and socialise with others, we communicate with people over the internet (some of us do this way too much!) But we are intrinsically in relationships.

There may of course, sadly, be people who are sick and old and who have no living relatives or friends. But even in that case, thankfully rare, a decision to take one’s life will affect those who are asked to participate in the process- doctors, nurses, others who are involved.

Indeed, in this area of “assisted dying”, we are usually well outside the area of an isolated act of suicide. We are speaking of a situation where someone demands the right, not to take their own life on their own, but to require a medical professional to help them take their life!

Ahdar quotes the renowned philosopher John Finnis, who has said:

Euthanasia... is not a private act, but precisely an act in which you seek assistance from someone else, or which you are asking someone else to carry out, sharing your intent to destroy your personal life. It is no more a private act than a duel or an agreement to sell myself into slavery.<sup>18</sup>

### (d) An argument from “autonomy” is not enough

Hence the argument from “autonomy” is not enough. For the law not to be changed to allow a doctor to kill someone, or to assist someone in killing themselves, is not a denial of a person’s “autonomy”. The law has never held that a person has the “right” to commit suicide, or the right to demand that someone else kill them. Nor do we have a “right” to live a pain-free or trouble-free or personally fulfilling life. None of these things are matters as to which we can demand the legal system must change to provide us with what we want.

It has to be said that the Supreme Court of Canada a few years ago handed down a controversial decision, *Carter v Canada (Attorney General)* 2015 SCC 5, in which it claimed that some sort of right like this existed, based on the Canadian Charter of Rights. In short, they were wrong!<sup>19</sup>

### (e) Undermining the long-held traditions of the medical profession

In particular, to change the law to allow (or, as has happened in Canada, to require) doctors to assist in causing death, is to fundamentally undermine the ethos that the medical profession has observed for thousands of years. That is no doubt why the major medical organisations continue to oppose euthanasia legislation.

<sup>17</sup> Best, 2017, near n 25.

<sup>18</sup> Ahdar, 2016, at 471, quoting John Finnis “Euthanasia and the Law” in *Human Rights and Common Good: Collected Essays: Volume III* (Oxford University Press, Oxford, 2011) at 258.

<sup>19</sup> This dismissive comment can be justified somewhat by reasons offered by Ahdar, 2016, at 473-474. As he points out, the “right to die” was astonishingly found in a Charter “right to life”, by a logical overhand loop in which the court said that a prohibition on easy euthanasia may have caused some terminally ill people to take their lives earlier than they would otherwise! The logic is not persuasive.

### Quinlan puts it well:

To date health professionals have not joined a profession intended to cause death. Many current practitioners may object on religious or conscience grounds to being required to participate in voluntary assisted dying. In practice many health professionals performing this role are euthanasia advocates and may have an actual or perceived conflict of interest. This is particularly so given that, a doctor has a fiduciary relationship of trust with their patient. Such a doctor may have been involved in assisting the patient to choose euthanasia and facilitated that objective. For example, Dr Nitschke paid for the fees of one of the psychiatrists who signed off on the availability of euthanasia for one of his patients during the brief operation of the NT Act.<sup>20</sup>

In other words, the very opening up of this option undermines the physician's oath to "cause no harm". And once doctors become advocates for euthanasia, it will be hard to avoid conflicts of interest.

The Australian Medical Association declares that "[t]he AMA believes that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of futile treatment".<sup>21</sup>

### (f) The Vulnerability of those affected, and pressure not to be a burden

Any human institution which assumes that all those involved will be acting purely from altruistic motives, is not one which is likely to be realistically workable. The fact is that assisted dying of, in particular, elderly persons who have children who are about to inherit from their parents, will often be in the interests of those children. Caring for a sick and elderly person is financially, physically and emotionally demanding. At the moment, while all those things are true, we have a clear "black line" rule: we do all we can to allow someone to live. But if assisted dying laws are passed, even with apparent safeguards, it will be very hard to stop some of those pressures leading, in some cases, to the elderly either being directly put to death without their consent, or else being the subject of emotional pressure to "go quickly" from family members.

Ahdar notes:

Much of the debate focuses upon the pleas by exceptional individuals who are intelligent, articulate and who clearly comprehend their predicament. Yet the law will have to protect everyone — the inarticulate as well as the articulate, the impaired, gullible or naive as well as the intelligent and alert.<sup>22</sup> The interests of the silent but vulnerable many are lost sight of in a desire to accommodate the desire of the few to control the timing of their death.<sup>23</sup>

As Best notes:

More sinister is the rise of elder abuse, with a recent investigation by the Australian Law Reform Commission finding that the most common form of abuse is financial, and that perpetrators are likely to be related to the victim.<sup>24</sup>

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<sup>20</sup> Quinlan, 2018, above n 8.

<sup>21</sup> "The Role of the Medical Practitioner in End of Life Care 2007" (amended 2014) Australian Medical Association [www.ama.com.au](http://www.ama.com.au), item 10.5. [https://ama.com.au/sites/default/files/documents/ps\\_on\\_the\\_role\\_of\\_the\\_medical\\_practitioner\\_in\\_end\\_of\\_life\\_care\\_2007\\_amended\\_2014\\_0.pdf](https://ama.com.au/sites/default/files/documents/ps_on_the_role_of_the_medical_practitioner_in_end_of_life_care_2007_amended_2014_0.pdf).

<sup>22</sup> Iona Heath "What's wrong with assisted dying" (2012) 344 BMJ e3755, quoted in Ahdar, 2016, at 493.

<sup>23</sup> John Keown in Emily Jackson and John Keown *Debating Euthanasia* (Hart, Oxford, 2012) at 97, quoted in Ahdar, 2016, at 493.

<sup>24</sup> Best, 2017, citing the Australian Law Reform Commission's (ALRC) report on elder abuse: *Elder Abuse – A National Legal Response*, [http://www.alrc.gov.au/sites/default/files/pdfs/publications/elder\\_abuse\\_131\\_final\\_report\\_31\\_may\\_2017.pdf](http://www.alrc.gov.au/sites/default/files/pdfs/publications/elder_abuse_131_final_report_31_may_2017.pdf).

None of us would like to think we would relate to our elderly relatives this way. But if there is one thing that lawyers know, it is that you rarely lose betting on the capacity for human greed and sinfulness.

Quinlan notes:

The evidence, of euthanasia occurring in the absence of explicit consent and in the absence of underlying illness, from other jurisdictions,<sup>25</sup> also supports the irrevocable argument against euthanasia. For example, a 1995 review of euthanasia in the Netherlands found that 0.7% of such deaths had occurred without explicit consent from the patient.<sup>26</sup> Pereira has noted that: in the Netherlands in 2005 1 in 5 people euthanised had not given explicit consent and that a Flemish study revealed that 32% of the euthanasia cases studied occurred in the absence of request or consent because the patients were comatose (70%), had dementia (21%), because the physician decided it was “clearly in the patient’s best interest” (17%) or because the physician has determined that discussing it with the patient would be harmful to the patient (8%).<sup>27</sup>

On top of the pressure that may be exerted by relatives, or decisions that are made by physicians, we would then have the “internal” pressure that an elderly and sick person would put on themselves, in a desire not to be a “burden” on family members. All these things may be further complicated if the sick person has a mental illness.

Best notes:

Australian legislators have suggested that potential recipients of euthanasia be reviewed by doctors and possibly a psychiatrist or psychologist before being allowed to proceed. However, there are problems with this as well. Stories from the brief period when euthanasia was legal in the Northern Territory show that the psychiatric review was seen more as a hurdle to overcome than a safeguard or an opportunity for treatment. Not everyone was completely honest in their responses.<sup>28</sup> Psychiatrists in Australia have expressed concern about their ability to assess the mental competence of a patient after seeing them only once. Of course, doctors regularly make decisions about a patient’s mental competence on a single meeting. But in the cases I can think of where that is required, the decision can be reversed down the track if a mistake is made. Not so, in this case.<sup>29</sup>

And it needs to be added that, once assisted dying is available to those with one kind of “intolerable” condition, physical pain, then the pressure will soon mount for it to be available to those who are depressed or find life “emotionally intolerable”. Indeed, we have seen examples of this already in allegations that suicide medications were made available to some who was simply “tired of life”.

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<sup>25</sup> In Switzerland, a recent study found that approximately 16% of those helped to die, by Dignitas and other organisations that provide such assistance, had no underlying illness: Nicole Steck et al. “Suicide assisted by right-to-die associations: a population based cohort study,” *International Journal of Epidemiology* 43 (2014): 1–9.

<sup>26</sup> Kissane, Street and Nitschke, “Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia,” 1101; Jose Pereira, “Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls,” *Current Oncology* 18 (2011): 2 esp. 39.

<sup>27</sup> Pereira, “Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls,” esp. 39. Some Dutch doctors do not recognise the right of a patient who has opted for euthanasia to change their mind: see Celeste McGovern, “Belgium’s Euthanasia Slippery Slope: Now It’s For Grief,” National Catholic Register, February 10, 2016, <http://www.ncregister.com/daily-news/euthanasia-doctor-in-belgium-i-dont-have-to-justify-myself-to-anyone-i-deci/>.

<sup>28</sup> D. W. Kissane, A. Street and P. Nitschke (1998) “Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia.” *The Lancet* 352(9134): 1097-1102.

<sup>29</sup> Best. 2017, near n 23.

## (g) “Bracket creep” is always likely to undermine existing protections

Finally, then, this is an example of the “bracket creep” that is likely to apply to any legislative protections or limits that are put in place. However carefully crafted the limits of a piece of legislation are, there will be people pushing the limits, and an emotive case made for the next “liberalisation” of the law to relieve some new type of suffering, or someone who just falls outside the current guidelines. The fact is that some moral decisions do require a clear, “black line” rule- and once this is crossed, there is no logical stopping point to expansion. If this sounds like a “slippery slope” argument, it is; a “slippery slope” argument of the sort that is perfectly valid.

As Quinlan notes, once we cross this line it will become increasingly difficult to maintain our general societal norms against so-called “ordinary” suicide, and laws that prohibit assisting in suicide.

For example, if the criteria require sufficient medical support for a diagnosis of likely death resulting from a diagnosed terminal illness within three months, what of the person with a diagnosis of three months and one week or four months or five months or a year? There is no logical foundation on which whichever period is set as the criteria can logically rest. If the objective of the introduction of voluntary assisted dying is to enable those in pain, or who consider that their life is not worth living because they have a terminal illness, [to die], on what foundation of logic does the State continue, in a voluntary assisted dying world, [to] refuse access to death by this means to those who profess to be in pain – physical or mental – but fall outside whatever criteria is set? As there can be no robust logical foundation on which a limited set of criteria is set, it is inevitable over time that in practice or in law, or in both, those criteria will not remain fixed.<sup>30</sup>

## 5. Conclusion

The arguments offered here are by no means the only reasons why we should not change the law to allow active killing of patients, or require the provisions of “assisted dying”. One thing that certainly would warrant more discussion is why we as a society are prepared to countenance moves that seem to radically undermine the value of all human life. Some may suggest we are partly there because of the way we have diminished the value of human life at its beginning (a topic for another whole evening!) Another reason, sometimes the “elephant in the room”, is that hospital administrators will always be looking for reasons to save money, and keeping people alive with a minimum of pain will sometimes be expensive. The general idea that we all have a right to a “pain free life” is also in the background.

But whether these or other reasons are offered, in my view such laws will be a bad idea, and we ought to pray that members of Parliament will continue to see that this is so.

## References and further reading

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<sup>30</sup> Quinlan, 2018, above n 8.

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