

Analysis and Commentary on the End of Life Assistance (Scotland) Bill

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Preliminary Comments

1. In some respects it is not surprising that this Bill contains so much in common with other Bills which from time to time have sought to legislate for euthanasia and assisted suicide. Attempts to introduce such legislation are fraught with the same sorts of problems – problems that cannot be avoided. For it is in the nature of the issue that there will be access to the legislation by those not originally intended as its targets.
2. The type of case that is often in the mind of those thinking about assisted suicide and euthanasia is a terminally ill person with perhaps a few weeks to live, who has serious untreatable pain, a clear and freely made decision to end their life and relatives whose only desire is for their welfare. It is however, simply not possible to frame a law limited to such ‘hard’ cases, as few of them as may exist¹. To attempt to do so is not only a failure to respect the essential human right to life which must be upheld, and indeed promoted, to ensure stable and safe communities, but also a failure to recognise the complexities of human life in which internal and external factors can bear so profoundly upon decisions about wanting to live or die. It is also a failure to recognise the incongruity in the effort to prevent suicide in the community, yet carve out circumstances where suicide is acceptable, or even at risk of being expected for some people. Even for the rare hard cases themselves, good palliative care can provide a reasonable measure of relief. It is also a failure to recognise the critical importance of the profession of medicine and its business of healing. The face of the profession changes disturbingly when physicians no longer work only to save and protect human life (for further analysis on this issue see *The Role of Medicine* below).
3. Reminiscent of another moral issue, namely abortion, where the initial debate and focus of legislation was upon the ‘hard’ cases such as rape and incest, euthanasia and assisted suicide would likewise be expected to escalate well beyond the types of cases which were initially the drivers of debate and objects of legislative change. Indeed, this has been the case in The Netherlands, where the bereaved, children, the depressed and lonely have all received euthanasia at the hands of the medical profession with permission from the state (see Appendix 2).
4. The law is a powerful educator. It is interpreted by members of the community who respect it as forming moral character and teaching ethical principles. If it were to sanction the terminating of innocent human lives, particularly those disabled or otherwise vulnerable, the fundamental message would be that there are some lives not worth living and it is acceptable to terminate them. Such a basic message, once accepted, will necessarily legitimize judgments about the value of any human life, thus empowering the strong over the weak. Human history is littered with the results of such imbalance.

¹ As it is, individual ‘hard’ cases may not be able to access this Bill because their choice may come at a time possibly within 2 weeks of natural death. Since the Bill requires a process that is longer than this, they cannot receive assisted suicide or euthanasia. It is therefore likely that if this Bill is passed, cases such as these will be used to apply pressure to change legislation to shorten the permissible timeframe, thereby placing pressure upon other vulnerable individuals to make a quicker decision.

The Bill's Reach

5. This Bill uses the euphemism “End of Life Assistance”, when in fact the Bill would permit both assisted suicide and euthanasia. This lack of clarity serves to mask what in fact would be permitted, and for an issue of such gravity, is unacceptable. For the community to clearly understand what this Bill is all about, they need fair and accurate terminology. That is the very least that should be expected. The term “assistance”, used throughout the Bill as well as in the title, can be construed to mean any number of ways to help someone at the end of life, most of which would be morally acceptable. Indeed, the term “end of life” itself commonly refers to the period of time prior to life’s end, rather than to actually terminating life by intervention. There is no doubt that euthanasia and assisted suicide are morally contentious. It could be argued that the public is not well informed about the ramifications of implementing euthanasia legislation and hence are more vulnerable to misunderstanding what is in fact the intent of the Bill. The Bill’s lack of clarity means that if it were to pass in its current form, it would not necessarily represent the wishes of the people.

6. This problem of lack of clarity is compounded because of the use of other terms throughout the Bill which are also diffuse and provide no certainty with regard to practices and outcomes. For example, regarding how assisted suicide or euthanasia would be administered in practice, the terms “assistance” and by “appropriate means” are not defined in any way, other than that they should occur with “dignity” and the “minimum of distress”. What constitutes “dignity” is likely to be highly variable in one person’s judgment compared to another’s. Many would consider it in principle contrary to human dignity for innocent life to be intentionally taken, regardless of means. Furthermore, a “minimum of distress” may involve considerable distress for some individuals, yet nevertheless be considered a minimum, given the circumstances. The point is, the subjectivity involved leaves open the possibility that some rather unpleasant means of death could occur and remain legally permissible. It would then require a case to be brought before the courts to clarify interpretation of the terms. Prior to that putative occurrence, some people may have been legally subjected to unnecessarily distressing deaths.

7. The key area of concern regarding the Bill’s reach relates to the categories of persons for whom it is said to apply, that is, the eligibility requirements. Persons must be 16 years of age or over, registered with a medical practice in Scotland for 18 months, and diagnosed as terminally ill and find life intolerable, or be permanently incapacitated so as not to be able to live independently, and likewise find life intolerable. These criteria are so wide as to potentially expose large numbers of people to euthanasia and assisted suicide, much like what is currently taking place in Holland. Even the intention to exclude “euthanasia tourism” is flawed, in that registration with a medical practice for 18 months does not stipulate residency for any more than 3 months. And in any case how is residency to be measured?

8. The Bill assumes that a 16 year old has the ability to make a life and death decision. This is not only seriously doubtful in itself, but when combined with the other criteria, makes for potential circumstances that would be truly devastating (see Appendix 1 for a hypothetical case involving a 16 year old that the Bill would permit). The vulnerability of people in certain circumstances, perhaps coming to terms with a medical condition, is well-known. That people can quite gradually come to terms with life’s circumstances after initially despairing is likewise a

common observation. How much more critical is such a phase for a 16 year old, with limited life experience and underdeveloped ability to make complex judgments regarding likely future scenarios. This Bill could put highly vulnerable young people at serious risk of having their lives ended because the prospect of a fulfilling life cannot yet be conceived.

9. If someone is terminally ill - by definition in the Bill having a progressive condition and a life expectancy of less than 6 months – they fulfill the conditions for euthanasia or assisted suicide. The requirement that the person also find life intolerable is effectively meaningless. Presumably anyone wanting assisted suicide or euthanasia no longer wants to live and would answer the question about whether they find life intolerable in the affirmative. It is an entirely subjective measure and not open to any objective scrutiny, so adds nothing to the criteria for eligibility.

10. Anyone who is newly diagnosed with a terminal condition is immediately in a very vulnerable position and their judgments may be skewed by the information they have been given. That information may only be available as an approximation based upon known similar cases for which there is likely to be considerable variation. Moreover, clinical judgment alone is unlikely to accurately predict survival². It has also been the case that diagnosis of a terminal condition has been incorrectly made by medical professionals. Take for example the widely reported case of John Brandrick, who was incorrectly diagnosed with pancreatic cancer and given 6 months to live. After dramatically modifying his lifestyle he was informed 12 months later that in fact he had had pancreatitis instead³. This type of error could result in someone making a life and death decision based upon uncertain information. Surely, it only takes one such case to make a law like this far too risky. It is often said that capital punishment must not be permitted in law because of the risk of terminating the life of one innocent person who has been wrongly convicted. The same applies here, for if this law is implemented there will almost certainly be someone who is euthanased based upon wrong information; for example, perhaps someone who has been wrongly diagnosed with terminal cancer, who otherwise would have lived a long and healthy life.

11. The second category of persons who can access assisted suicide or euthanasia is the category which is really open to a wide variety of people. As already pointed out, whether the person finds their life intolerable or not is guaranteed for someone seeking euthanasia or assisted suicide; therefore, the categories used to permit access remain permanent physical incapacity and independence. In reality, there is a large crossover between these terms and a broad spectrum of conditions of permanent physical incapacity coupled with dependence – itself a loose term open to considerable interpretation.

12. One might argue that only those people with serious disabilities and serious dependence upon others would want euthanasia or assisted suicide – given the natural inclination of persons towards life. However, there have been cases of people simply tired of life who have sought euthanasia⁴, and such cases amongst people with minor disabilities could easily arise. In addition, disabled persons, who may have internalised a belief that they represent a considerable

² Chow, E *et al.*, How accurate are physicians' clinical predictions of survival and the available prognostic tools in estimating survival times in terminally ill cancer patients? A systematic review. *Clinical Oncology* 13(3):209-218, 2001. The authors conclude, "... there is weak evidence to support that clinicians' estimates alone could be specifically employed for survival prediction."

³ See <http://www.dailymail.co.uk/news/article-453095/Patient-given-wrong-diagnosis-year-live-faces-bankruptcy.html>

burden to loved ones or perceive their lives as useless and without purpose, may seek euthanasia. If they meet the objective criteria of dependence and permanent physical incapacity of even a minor level, what or who will stop them accessing assisted suicide or euthanasia under a law such as the one here being proposed? It is hard to escape the notion that the underlying ethical premise in this Bill is that an autonomous choice is all that is really required. However, good ethical judgments require far more than autonomy alone. Good ethical judgment must at the very least also include doing no harm, acting justly and promoting the welfare of the patient (beneficence).

13. Furthermore, despite the role of the psychiatrist in this Bill, persons who are disabled and dependent and also depressed, might seek assisted suicide or euthanasia because of their untreated depression. It is unclear whether depression would qualify as a circumstance to preclude assisted suicide or euthanasia. The term “mental disorder” is defined in this Bill in the same way as it is in the *Mental Health (Care and Treatment)(Scotland) Act 2003*: as mental illness, personality disorder or learning disability. The *Mental Health Act* is primarily intended for mentally ill offenders and therefore the meaning of “mental disorder” is unlikely to include depression.⁵ The issue of depression is always difficult, since it may be expected to be present in the circumstances envisioned by this Bill. If psychiatrists do not consider depression a mental disorder, as defined by the Bill, they may provide a positive report to the designated practitioner, leading to assisted suicide or euthanasia of a depressed person who might otherwise receive treatment, recover from their depression and want to live. If this Bill does not demand that psychiatrists treat their patients for depression before signing off on their euthanasia request, a great disservice has clearly been done to vulnerable patients to whom traditionally a psychiatrist would owe a duty of care to ensure the person has been adequately cared for.

14. There are also other circumstances, which would be unknown to a designated practitioner, which may be the real factor driving a disabled and dependent person to seek assisted suicide or euthanasia. Many people in the community struggle with addictions of various sorts which can cause them enormous distress. Such addictions may be to legal or illegal substances, gambling or other behaviours, and can be a source of considerable torment. Indeed, suicides in the community do result from these personal battles which some may have waged for many years. There can be no certainty that these issues will be revealed or otherwise detected in those seeking assisted suicide or euthanasia. Moreover, addictions are specifically excluded from the definition of ‘mental disorder’ found in this Bill.⁶ So in fact rather than disability being the real driver, some other source of [non-physical] pain may be the real issue. It will be a sad indictment on the community if assisted suicide or euthanasia is provided for such vulnerable individuals.

15. There are two separate legislatures from which there is evidence that those seeking euthanasia or assisted suicide are vulnerable and do not fit the classical hard case often promoted by advocates for legislative change. The first comes from The Netherlands and concerns the case of

⁴ For example, the case of Lisette Nigot, a healthy 79 year old retired Professor who was tired of life. See Carmelo Amalfi *et al.*, Healthy woman thanks Dr Nitschke, then kills herself, *Sydney Morning Herald*, Nov 2002. See <http://www.smh.com.au/articles/2002/11/25/1038173695743.html>

⁵ Lindsay D. G. Thomson, The Mental Health (Care and Treatment) (Scotland) Act 2003: legislation for mentally disordered offenders, *The Psychiatrist* (2006) 30: 423-429. doi: 10.1192/pb.30.11.423 See <http://pb.rcpsych.org/cgi/content/full/30/11/423>

⁶ See http://195.99.1.70/legislation/scotland/acts2003/asp_20030013_en_31#pt23-11g328

Ms Hilly Boscher⁷. Ms Boscher was in her fifties, physically healthy, but suffering emotionally. One son had suicided, the other died from cancer, and then divorce ended her marriage. Two months after the death of her son she sought assisted suicide and soon received it with the help of her doctor, a psychiatrist who failed to acknowledge her depression and agreed with her that her life was not worth living. Hers is one of the few Dutch assisted suicide cases to come into the public gaze, but it highlights something deeply problematic about Holland's experiment with medical killing – for more detail on aspects of euthanasia in The Netherlands see Appendix 2. The second comes from Australia's brief experiment with euthanasia in the Northern Territory in 1996. During the 6 months that the legislation was in effect, seven people made formal use of the legislation, with four eventually being euthanased. Details of the cases were published in the medical journal *The Lancet*.⁸ All seven had cancer, none had severe pain, three were socially isolated, symptoms of depression were common, and for at least one, the treatment prognosis was good. Medical opinion differed about the terminal nature of their illnesses. These two examples alone are sufficient to show that legal access to euthanasia attracts lonely, depressed and isolated individuals for whom much could be done to improve their circumstances. That the community failed these people reveals deep problems that access to assisted suicide or euthanasia would only intensify.

Protective Mechanisms

16. This Bill sets up a series of mechanisms intended to ensure that individuals are making an informed decision that is fully voluntary, persistent, free of coercion and properly informed. The following describes the process:

- Person makes formal request in writing witnessed by two people (unrelated and with no interest in the person's death). Witnesses must be assured that the person understands their request, is acting voluntarily and not under undue influence.
- The person sees a psychiatrist, who ensures the appropriate information has been given including alternatives, capacity, voluntariness, undue influence, and mental disorders.
- A designated practitioner meets with the person to consider the formal request and the psychiatrist's report. The designated practitioner ensures that the same issues as have been covered by the psychiatrist are also to his or her satisfaction. The request is signed.
- The person, after approval of the first request and between 15 and 30 days of receiving that approval, makes a second formal request like the first one. As in the first request, two witnesses are required – they need not be the same witnesses as in the first request.
- The person sees a psychiatrist again and the same issues are dealt with and reported to the designated practitioner. The psychiatrist need not be the same psychiatrist as after the first request.

⁷ For a description of the 'Chabot Case' involving Ms Boscher, see <http://www.euthanasia.cc/dutch.html#cases>

⁸ Kissane DW, Street A & Nitschke P, Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern territory, Australia, *The Lancet* 352(9134):1097-1102, 1998.

- If satisfied, the designated practitioner approves the second request and agrees in writing with the person as to the place, means and person to administer assisted suicide or euthanasia.
- After 2 days have passed, but before 28 days, assisted suicide or euthanasia may be provided by someone unrelated to the person and with no interest in their death. The designated practitioner must be present. Alternatively, the designated practitioner may administer assisted suicide or euthanasia alone with the person. The person may withdraw their request at any stage by any means.

17. This process has the appearance of rigour because it entails repetitive steps, witnesses, two medical professionals and time delays. However, there is every reason why such a process could easily become routine and those involved acquiesce to the lowest common denominator – the bare minimum letter of the law. Despite the fact that by far the majority of medical professionals are diligent and would carefully attempt to ascertain what is going on with their patient so as to seek their genuine best interests, there will remain a minority who will merely tick the boxes. In doing so they will have acted legally but entirely inconsistently with the ethical principles of their profession. Moreover, the designated practitioner need not have any other knowledge of the patient beyond first presentation. A physician who knows the patient well and has experience with treating them is not required to be involved in any way. This reality highlights the fact that in the real world, human decision-making and interactions are complex and woven through with details that are highly relevant to the doctor/patient relationship – details that if left out could result in an impoverished standard of care, and with regard to the subject matter of this Bill, potentially result in the death of the patient.

18. At first glance, the requirement for a two-stage process adds greater scrutiny to the request for euthanasia. However, because potentially just one medical practitioner can see the patient twice, and likewise one psychiatrist can see the patient twice, it is likely that on the second occasion both designated practitioner and psychiatrist will be conditioned to more readily accept a request. So in fact little is added by a two-stage process that does not actually require genuine alternative opinions. The principle of requiring alternative opinions, so basic in many situations in medicine, is based upon the idea that a new consideration of the circumstances is often necessary for patient welfare, a consideration that is based not only upon the details of the patient and his or her request, but upon the differing capacities to judge astutely that pertain to different medical professionals. One of the problematic notions that the medical profession is dealing with in the modern era is a pressure from some quarters to turn medical professionals into mere service providers who will merely do what is asked of them. This idea is contrary to good medical practice and should be resisted. A sound understanding of medicine requires that medical professionals act on the basis of established principles that combine best evidence, sound ethics, details about the patient, and careful critical judgment.

19. When it comes to witnesses, it is a relatively straightforward matter to find two people who will sign off on a form. All they are required to do is ask whether the person understands what they are doing, is not under undue influence and is therefore acting voluntarily. In each case the means for determining these things is fraught. At one end of the scale a witness may wisely probe the real reasons for someone's choices at a depth that does justice to the real complexities including internal and external pressures; however, at the other end is someone who simply asks,

“Do you know what you are doing and are you acting voluntarily without undue influence?”
After receiving an affirmative answer the witness signs on the dotted line.

20. While there is sense in ensuring that the witnesses cannot be relatives because they may have an interest in the person’s death (their estate), a stranger who does not know the person well is far less likely to be able to determine whether a risk of internal or external undue influence exists. This dilemma simply serves to highlight how fraught is any process by which someone can sign off on the death of another.

21. The Bill stipulates that in the particular case where someone resides in a care home service, one of the witnesses must be an employee who knows the person well. Why knowledge of the person is required when the person resides in care, but not for someone who doesn’t, is unclear. In any case, it may be that an employee acting as a witness, who knows the person well and finds them quite difficult to care for, would actually have an interest in their ‘departure’.

The Final Step

22. Once the process of obtaining a written approval to the second request has been completed, the designated practitioner and the person agree in writing to the fact that the person’s life will be ended, who will do it, where it will happen, and what means will be used.

23. As noted earlier, there is considerable lack of clarity regarding the actual means, leaving open all manner of possibilities. While it may seem morbid to suggest that euthanasia could be administered by means that some would find shocking, the Bill only requires that subjective judgment be made about the death having “dignity” and a “minimum of distress”.

24. The designated practitioner may be the one assisting with the suicide, or administering euthanasia. However, while the designated practitioner is required to be present, another person or persons may assist with the suicide or administer euthanasia. This raises several issues.

25. First, if someone else is administering euthanasia, will they be acquainted with the means to be used? What medical expertise will they have regarding lethal injections, doses, or adverse reactions? It is not sufficient to simply have the designated practitioner present to direct things. This may effectively constitute teaching someone to carry out a task normally done by medical professionals. This is unacceptable.

26. Second, if the designated practitioner is the only one present, he or she remains the only witness to the person’s death. This places a great deal of trust in a practitioner who is directly ending someone’s life and who knows that if anything were to go wrong, no witness exists. The Bill stipulates that the person may revoke their request at any stage, by any means formal or informal. If such revocation were to occur in the moments just prior to the ‘assistance’, and perhaps by relatively subtle means, the powerful position held by the designated practitioner in contrast to the patient, risks an over-riding judgment made by the practitioner to proceed anyway. There is already evidence from Holland that practitioners sometimes administer euthanasia where there has been no request from the patient. In such circumstances, the doctor is making a judgment about the life of the patient that does not take into consideration the patient’s wishes, or at the least presumes to know what the patient would want. A designated practitioner who may

have gone through a long and detailed process with the patient, is in full agreement with the euthanasia going ahead, yet finds a weakening of resolve on the part of the patient at the last moment could easily apply pressure (subtle or not) to complete the process. In the end there is no witness to argue that the practitioner should really have stopped.

27. The converse is also possible. Perhaps at the last moment the designated practitioner will have the weakening resolve and want to stop. Yet in the close one to one relationship between the two, without anyone else present, the practitioner may be pressured by the person to act.

28. Such undue influences, so often mentioned in the Bill, cannot be regulated in these final moments, and remain deeply problematic.

The Role of Medicine

29. What this Bill proposes constitutes a complete break with the principles and tradition of law and medicine. The law does not allow doctors to end a patient's life, nor does medical practice condone or indicate the intentional ending of a patient's life as some form of treatment.

30. Ending a patient's life is not a part of medical practice, because in principle, it contradicts both the theory and the aims of medicine. The underlying aim of medicine is, and has always been, the health of the patient. The role of the doctor is to treat the patient in accordance with the patient's best interests. Throughout history, medical ethics has recognised the principles that drive and also limit a doctor's actions. Thus, medical ethics has identified health as a fundamental or self-evident good; something of obvious and unmistakable value to all human beings. A doctor's actions with regard to the patient must therefore be directed always toward the health of the patient.

31. At the same time, sound ethics and good medical judgment have together recognised that the health of the patient is not always furthered by the aggressive treatment of disease and illness. What this means is that the health of the patient must be construed not simply in terms of fighting the illness, but by weighing the benefits and burden of each treatment option. Good medical decision-making allows doctor and patient together to evaluate the benefits and burdens of every relevant treatment. It is this rationale that justifies and validates the decision to forego treatments where the benefit of treatment (in terms of improved capacity, life expectancy, etc) is outweighed by the burden (in terms of side-effects, risk, reduced capacity, pain, cost, etc). Yet it is vital to recognise that this weighing of benefits and burdens is only the nuanced application of the pursuit of the patient's health. It presumes that the doctor and patient are together seeking the most appropriate treatment with the shared aim of improving the patient's health.

32. In this context, the concept of euthanasia is a distortion of the doctor's fundamental role. The premise of euthanasia is that it may be in a patient's best interests for his or her life to be ended. Note that this premise directly contradicts the traditional and historic aim of medicine as the health of the patient. To consider ending the patient's life as a 'treatment' for the advancement of the patient's health is absurd.

33. Euthanasia is in fact radically different in principle and in aim. It is not compatible with the principles and aims of medicine, as epitomised in the injunction "Above all, do no harm". The

aim of euthanasia is death, not health. The principle by which it functions is not the careful weighing of benefits and burdens for each medically indicated treatment option, but (in the context of this Bill) the autonomous request on the grounds of a subjective account of ‘intolerable suffering’.

34. How does this interpretation of euthanasia measure up against medical decision-making? First, as mentioned above, euthanasia does not further the health of the patient. Rather, it *ends* the health of the patient. Second, patients do not have the right on ethical grounds or in law to demand unnecessary treatment, yet the primary basis for euthanasia is the patient’s demand. Third, the indicator for euthanasia is the patient’s self-assessed level of suffering, which is required to be at an ‘intolerable’ level. Yet ‘suffering’ is not a symptom; pain is of course a symptom, but suffering is not. The proper response to pain as a symptom is to investigate its causes, and relieve the pain if possible. But what is suffering? Does it include existential suffering? Mental suffering? Emotional suffering? The self-assessed degree of suffering is entirely subjective. ‘Intolerable’ does not tell us how severe the suffering is, instead it indicates the patient’s ability or willingness to tolerate the suffering.

35. These points demonstrate how incongruous and exceptional euthanasia is in the context of medicine. If euthanasia or assisted suicide were to be legally permitted, it would constitute an assault on the fundamental principles of medicine and a subversion of the medical profession. It will introduce aims, standards, and principles that are contrary to medical practice.

Legislative Creep

36. One of the most serious problems associated with any assisted suicide or euthanasia legislation is that once the key principle - that the state must protect innocent human life - is surrendered, it becomes impossible to contain the law from further change. This is because there is no enduring basis for retaining either the access criteria or the particular limitations and safeguards. Where genuine medical treatments are concerned, the limitations are obvious since the aim of medical treatment is to promote the health of the patient, only those treatments which do promote health are acceptable. But euthanasia has no such *in principle* limitations. Unlike the whole of medicine (see *The Role of Medicine* above), there is nothing *objective* about the patient’s condition to tell us that euthanasia is necessary or appropriate. Instead, euthanasia is justified according to subjective factors such as the patient’s request, and their self-evaluated level of suffering; as well as factors such as whether the patient’s condition is terminal or not, itself open to considerable interpretation.

37. It is the lack of objectivity in euthanasia that leaves it open to expansion. Why, for example, should euthanasia not be allowed in cases where an individual says their suffering is intolerable and yet they have neither a terminal illness nor a disabling condition?

38. The same accusation of arbitrariness applies to the age restriction in the Bill. In Holland legislation now permits euthanasia of 12-16 year olds and in the Groningen Protocol, infants are being euthanased and pressure applied to the Government for legislative change. Clearly, the euthanasia of an infant involves no voluntary request. What is the sound basis for restricting euthanasia or assisted suicide to 16 years and over, when the Bill appears to be grounded in the idea that there are some lives no longer worth living, or simply *not* worth living?

Other Matters

39. This Bill makes no provision for conscientious objection by medical professionals. This is a serious oversight in a Bill that clearly deals with matters of conscience. This is of particular concern given the fact that freedom of conscience is under pressure in other contexts. For example, it has been suggested that conscientious objection should only apply to actual participation in an abortion, and therefore medical practitioners should be obliged to refer their patient to another practitioner who they know will either conduct an abortion or refer for one⁹. Would such pressure likewise be applied if euthanasia legislation were to be passed?

40. Medical professionals must be free to exercise their conscience and refuse participation in any 'treatment' which they consider unacceptable on religious, cultural or moral grounds. This also means that practitioners who become involved in various stages of the request procedure, but become more and more concerned with aspects of the process, should be able to withdraw for reasons of conscience if they so desire.

41. This Bill makes no mention of any reporting requirements. Controversial practices such as this, if to be permitted, require a formalised reporting structure so that the public is aware of what has been taking place. If assisted suicide and euthanasia remain hidden from proper ongoing public scrutiny, there is a risk that its actual practice may turn out to be something the public had not envisioned and no longer want. This would really constitute a form of necessary public scrutiny of what its leaders have instituted. At the same time it would introduce some accountability for those leaders.

42. There is a similar issue regarding accountability in that a matter of such gravity should not be left solely to the medical profession to deliberate upon. The Bill makes no provision for a board or committee of oversight to regulate what takes place. As already discussed, the Bill's reach is potentially so broad that what could eventually taken place may morph well beyond what was intended. Without proper oversight, it is likely that certain sectors of the medical profession will become the sole dispensers of assisted suicide and euthanasia. Neither suicide nor euthanasia, if ever implemented, should ever become simply other forms of medical 'treatment' offered by medical professionals. Professional accountability for such serious issues should entail supervision by a board or committee which comprises other professionals such as palliative care specialists, psychologists, ethicists, patient advocates, philosophers and others.

43. There remain some peripheral issues that are not without consequence. One is the manner in which life insurance will be dealt with. Currently, if someone commits suicide, life insurance cannot be paid out. The reasoning behind this is that a vulnerable person may see their demise as a gift to relieve their loved ones of the burden they perceive their own life to be at the same time as providing financial gain for them. Will insurance companies still pay life insurance for legally instituted assisted suicide and/or euthanasia? Should they? What would an insurance company do if someone significantly increased their life insurance, then sought euthanasia? The person's

⁹ Royal College of Obstetricians and Gynaecologists, *The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guideline Number 7*, at 3.4, p16, September 2004. See also: The National Health Service (General Medical Services Contracts) Regulations 2004, Schedule 2, Regulation 16, Contraceptive services 3(2)(e), which require the following: "where the contractor has a conscientious objection to the termination of pregnancy, prompt referral to another provider of primary medical services who does not have such conscientious objections."

intention need not be disclosed at the time of application. If a Bill were to mandate paying out any life insurance for euthanasia – as has been attempted¹⁰ - how would insurance companies respond? This is a problem that must be addressed, particularly as it goes to the question of undue influence upon a decision to seek assisted suicide or euthanasia.

44. Organ donation is an area of ethical deliberation that is currently being seriously debated worldwide and under considerable review. Some of the debate concerns whether the traditionally understood requirement for the donor to be dead – either by brain death criteria or cardiac death criteria – should still hold. It has been argued¹¹, that the dead donor rule should be dispensed with and instead greater consideration be given to the wishes of a person to be a donor, who may be ‘dying’ rather than actually dead. This matter raises considerable questions when coupling euthanasia and organ donation. It is likely that someone seeking euthanasia may also want to be an organ donor. Given that their express wish is to die, it may be considered acceptable by some to modify the means of euthanasia to enable organ retrieval under the types of conditions best able to preserve organs in a state suitable for transplant. Hence, euthanasia could become a source of superior organs for transplant. Is such an idea acceptable? The person may still be alive during organ removal, and indeed, organ removal may be the means of death. What will this do to the primary notion behind organ donation that it is a gift of life? Would damage be done to this hard fought public ideal if it were to be coupled with something as morally abhorrent as euthanasia?

Conclusion

45. There are numerous practical problems with this Bill that have been discussed in this analysis, practical problems that cannot simply be rectified by changes here and there. Indeed, it is recognised that some may be tempted to use this critique in an attempt to ‘tighten up’ the Bill. That would be a serious mistake because it would miss the whole point – that any attempt to legislate for assisted suicide or euthanasia undermines the most basic and fundamental foundation upon which stable societies are built, which is that the State has a duty to protect human life. In international law the right to life, like the right to liberty or freedom, is seen as an ‘inalienable’ right, a right of which I cannot be deprived and of which I cannot even deprive myself. This universal understanding of the rights to life and to personal liberty as ‘inalienable’ rights is based upon an understanding that the legal right to give up these inalienable rights threatens others who do not agree to have those rights taken from them. It is most acutely so for the inalienable right to life. The State’s human rights obligations require it to protect the right to life of all citizens, particularly the weak and the vulnerable. From this duty it must not waver.

¹⁰ In 2009, a Bill before the South Australian Parliament, the *Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008* sought to make the payment of life insurance mandatory upon euthanasia of the patient. The Bill also made it an offence for an insurance company to inquire about any existing request for euthanasia. Therefore, in effect someone could significantly increase their life insurance immediately prior to euthanasia leading to a windfall for relatives. See [http://www.legislation.sa.gov.au/LZ/B/CURRENT/CONSENT%20TO%20MEDICAL%20TREATMENT%20AND%20PALLIATIVE%20CARE%20\(VOLUNTARY%20EUTHANASIA\)%20AMENDMENT%20BILL%202008_HON%20MARK%20PARNELL%20MLC/B_AS%20INTRODUCED%20IN%20LC/CONSENT%20EUTHANASIA%20AMENDMENT%20BILL%202008.UN.PDF](http://www.legislation.sa.gov.au/LZ/B/CURRENT/CONSENT%20TO%20MEDICAL%20TREATMENT%20AND%20PALLIATIVE%20CARE%20(VOLUNTARY%20EUTHANASIA)%20AMENDMENT%20BILL%202008_HON%20MARK%20PARNELL%20MLC/B_AS%20INTRODUCED%20IN%20LC/CONSENT%20EUTHANASIA%20AMENDMENT%20BILL%202008.UN.PDF)

¹¹ Truog RD & Miller FG, The dead donor rule and organ transplantation. *New Engl J Med* 359(7):674-5, 2008.

Appendix 1 – Hypothetical Case

The following hypothetical case would be legally permitted by this Bill if it were to pass:

Peter is 16. He is a talented footballer, with really exceptional abilities. He has been approached by some of the big clubs to train with them and several coaches expect him to become a prominent player on the national and possibly international stage. He loves life, loves his football and everything is pointing towards a magnificent future. However, following a terrible car accident, his right leg is so badly shattered that he is confined to a wheelchair and told he will never play football again. His world collapses and the thought of life spent like this seems intolerable to him. After months of despair he finds himself contemplating suicide. Concern by family and friends connects him with psychological assistance, but it he still struggles to see that life is still worth living. His family and friends become worried that he may do something foolish. Peter becomes aware that there is a legally available means for him to end his life. He fits the legal category of someone who is “permanently physically incapacitated”, finds “life intolerable”, and “cannot live independently”. Not wanting to upset family or friends he begins the process in secret knowing that his privacy will be respected. He goes through the required checks and balances, finding no trouble accessing medical practitioners and psychiatrists who think his choice must be respected (following passage of the legislation, it was not long before the “euthanasia doctors” became widely known). Just months after his accident he receives a lethal injection at the hands of a medical practitioner in a private hospital far from home. Needless to say, his family is in complete shock at the news and the repercussions of his actions reverberate through his circle of friends. Neither friends nor family really ever recover from this and wonder how the medical profession with the blessing of the state could have done this to their son.

Appendix 2 – Non-Voluntary Euthanasia in Holland

The Netherlands allows the practise of voluntary euthanasia through certain case law judgments which set up the ‘strict’ conditions which must apply. The Dutch evidence set out in the Rummelink Report shows that, in 1990, there were 10,558 cases of medical decisions at the end of life which involved the ‘explicit’ intention to hasten the end of the life of the patient by act or omission. There were 2,300 cases classified as ‘euthanasia’; 400 cases classified as ‘assisted suicide’; 1,000 cases of administering drugs ‘with the explicit purpose of hastening the end of life’ without explicit request; 1,350 cases of the administration of opioids ‘with the explicit purpose of shortening life’; 4,000 cases of withholding or withdrawing treatment, without explicit request, ‘with the explicit purpose of shortening life’; and 1,508 cases of withdrawing or withholding treatment, on explicit request, ‘with the explicit purpose of shortening life’.

Of these 10,558 cases where there was an ‘explicit’ intention to hasten the end of life by act or by omission, 55% were non-voluntary. Put another way, in the practice of euthanasia in The Netherlands, more are killed without their knowledge and consent than with their knowledge and consent.

The authors of the Rummelink study have conceded that voluntary euthanasia inevitably leads to non-voluntary euthanasia. In an essay in the Hastings Center Report, the prestigious American bioethics journal, they said:

“But is it not true that once one accepts [voluntary] euthanasia and assisted suicide, the principle of universalizability forces one to accept termination of life without explicit request, at least in some circumstances, as well? *In our view the answer to this question must be affirmative.*” [Emphasis added].