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Name:	Professor Margaret A. Somerville AM
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QUESTIONING THE WISDOM OF LEGALIZING EUTHANASIA

Submission to the NSW Legislative Council's Standing Committee on Law and Justice
Inquiry into *Voluntary Assisted Dying Bill 2021*

15th November 2021

by

Margaret A. Somerville

AM, DSG, FRSC, A.u.A (pharm.), LL.B. (hons), D.C.L.,

LL.D. (hons. caus.), D.Sc.(hons. caus.), D.Hum.Let.(hons. caus.).

Emerita Samuel Gale Professor of Law; Emerita Professor, Faculty of Medicine;

Emerita Founding Director, Centre for Medicine, Ethics and Law, McGill University,

Professor of Bioethics, School of Medicine (Sydney campus),

Affiliate of the Institute for Ethics and Society, University of Notre Dame Australia

Thank you for your kind invitation to make a submission to your Committee about the legalisation of euthanasia and doctor-assisted suicide (Voluntary Assisted Dying (VAD)) in New South Wales.

As an academic specializing in bioethics and medical law and a commentator in the public square, I have researched, written and spoken on this topic for over forty years. (A short biography is included as Appendix A.) Some of the questions I have asked myself in undertaking this work and my responses to them are briefly set out in the attached Appendix B, which I invite you to read. I will mention just a few summary points in this text. (For references supporting the statements I make in this Submission, see Appendix B.)

We share a common goal: to do good and to relieve suffering…

First, I want to emphasize that the people on both sides of the euthanasia debate are well intentioned and believe they are fighting for the greater good, it is just that we do not agree on what that is. None of us on either side wants to see people suffer and we all agree that we have obligations to relieve suffering, especially healthcare professionals.

Moreover, the euthanasia debate is not about *if we will die* – we all will at some point. The debate is about *how we will die* and whether some ways of dying, namely euthanasia, are unethical and dangerous, especially to vulnerable and fragile people, and are destructive of important shared values on which we base our societies.

If it legalises “voluntary assisted dying”, the NSW Parliament will be responsible for allowing doctors and nurses to inflict death on (kill) their patients. This is not colourful language; this is a fact and you must be able to face that fact before you would legalize euthanasia. In a secular society like Australia, law and medicine bear the burden of upholding the value of respect for human life which religion once did. Euthanasia destroys their capacity to do that because the law changes to allow intentionally taking life and medicine implements that permission. Keep in mind that respect for life must be upheld at two levels: for each human life and in society, in general.

Impact of legalizing euthanasia on the socio-cultural paradigm …

I suggest Canada is the jurisdiction most likely to predict how euthanasia would unfold in NSW. Consequently, I would like to draw on my extensive experience on this issue in that country and focus on some broad cultural issues it raises.

Legalizing euthanasia is not, as pro-euthanasia advocates argue, just an incremental evolution of the socio-cultural paradigm on which we base our society. It is a radical revolution overturning some of our most important and fundamental values that have guided us for millennia as a society.

We must plan for the long term

Victoria, Tasmania, Queensland, South Australia and Western Australia have already legalised “voluntary assisted dying”. That is not necessarily a reason for following them. Unanimity or even legalization does not mean what is permitted is ethical. At one stage, all of the states permitted Aboriginal people to be paid less than Australians with European backgrounds; unanimity did not make it right.

The case for legalizing euthanasia is easy to make in Western democracies like Australia because utilitarianism (good ends or outcomes, relief of suffering, justify means, euthanasia);

moral relativism (nothing is absolutely or inherently wrong, rather right or wrong depends on the circumstances and the individual person's preferences); and rights to autonomy (my body, my choice) shape the dominant worldview. The sole focus of the case for euthanasia is on the individual person and the present.

The case against euthanasia is much more difficult to promote, not because it is weak – it is not – but because it is more complex.

I am not a utilitarian but there is a strong utilitarian case against euthanasia: that its risks and harms far outweigh its benefits. This case requires looking, not just to the present, but also to our "collective human memory" for lessons from the past and to our "collective human imagination" to try to anticipate the full, wider and long-term consequences of legalizing euthanasia. In addition, it requires considering the wider impact of legalizing euthanasia than just that on the individual suffering person, important as that person is.

Many non-Indigenous Australians, especially younger ones, are increasingly recognising how fortunate we are to have the over 60,000-year-old Aboriginal culture from which to learn about seeking wisdom by looking to the past and to the future and not just the immediate present. We must consider both individuals and the "mob" -- the "common good". Nowhere is this more important than in relation to decisions about legalizing euthanasia. Aboriginal Elder Senator Patrick Dodson has made an outstanding contribution in this regard. Legalizing euthanasia would be inconsistent with Aboriginal culture. (*Finishing Up Business: What we can learn from Australia's First Peoples about dying and death,* PM Glynn Institute, Occasional Paper No.6, 2021)

The "ethical tone" of a society is not set by how it treats its most powerful, privileged, and wealthy members, but by how it treats its most fragile, vulnerable, and poor ones. The latter include not only terminally ill people, but also, fragile elderly people and those with disabilities, who are the most at risk from euthanasia. In short, euthanasia will change the "ethical tone" of our society.

The Australian Law Reform Commission report on Elder Abuse emphasized this danger. It concluded that between 4 and 14 percent of elderly people are abused, most often by a close relative. The Commission was concerned in particular about "early inheritance syndrome". Many people worry about the cost of residential care for their elderly relatives and presumptive heirs see "their" inheritance, to which they feel entitled, dissipating. Imagine the likely consequences of a combination of "early inheritance syndrome" and "early death syndrome".

In the long-term, the "slippery slope" is real and relevant

Lobbyists for euthanasia mock the slippery slope argument as a logical fallacy. This is consistent with their short-term view; they are not interested in future-proofing legislation or, indeed, might rightly fear that doing so would undermine their pro-euthanasia stance. .

Andrew Denton, of the euthanasia advocacy group *Go Gently Australia*, once explained to me that there can be no "slippery slope" when the next step is a good and welcome development, it would only be present if that were not the case. Experience shows that once legalized, euthanasia very quickly becomes normalized and the "logical slippery slope" (the major expansion of who may have access, on what conditions and in which circumstances) and the "practical slippery" slope (failure to comply with the law) are unavoidable. Moreover, each further step in the process of normalization begets yet another, which, likewise, is viewed as good and welcome.

At the bottom of the "logical slippery slope" is rational suicide, the absence of any restrictions on access to euthanasia. This is the position of Dr Philip Nitschke, for instance, and is being proposed by some advocates in Canada. It makes logical sense. The justification for legalizing euthanasia is respect for an individual's right to autonomy and the argument is that this should not be restricted by requiring certain conditions or permissions.

In the Netherlands the government is currently considering proposals that being "over 70 years of age and tired of life" or feeling that one has "a completed life" should be sufficient grounds for euthanasia. Similarly, in Canada, restrictions for access to euthanasia are being challenged as a form of legally actionable discrimination; the original law's requirement for death to be "reasonably foreseeable" has been removed on this ground as discrimination against people who are suffering, but not terminally ill.

Examples of the "practical slippery slope", that is, once euthanasia is legalized it is provided not in accordance with the law, are legion. One study of doctors in the Flanders region of Belgium who had euthanized patients found that, by their own admission, 27 percent had done so on at least one occasion not in accordance with the law.

In the long-term, safeguards will be relaxed

The pattern is that legislators who first approve euthanasia do so with "strict safeguards", such as we see in the *Voluntary Assisted Dying Bill 2021*. However, these are quickly relaxed and the people who may have access and the conditions are greatly expanded.

Again, Canada provides a powerful example. As mentioned, it has deleted from its MAiD (Medical Aid in Dying) legislation a requirement that "death be reasonably foreseeable". In 24 months' time, the law will allow people with serious mental illness, but no physical illness, to access euthanasia. The Canadian Parliament is also currently considering whether to amend the MAiD legislation to allow people with early dementia to give "advance directives" consenting to euthanasia to be carried out when they are incompetent to consent. Euthanasia for children is also under consideration.

If the current NSW VAD bill succeeds, it will be amended time and time again. Parliament will be asked to extend the provision of euthanasia to people who are chronically, not terminally, ill; to babies; to children; to mentally ill and severely depressed people; to people who are tired of life; and to those who are demented. These are not fanciful scenarios; one or more of them are already taking place or being considered in the Netherlands, Belgium and Canada.

In the long-term, euthanasia will not be rare

Euthanasia advocates often propose that euthanasia will be rarely used and only as a last resort. This is, at best, wishful thinking. Health Canada's *Second Annual Report on Medical Assistance in Dying* gives the total number of MAiD deaths since the legislation came into effect in June 2016, as 21,589. In 2020, 2.5 percent of deaths in Canada were by MAiD and the total number of deaths by MAiD had increased by 34.2 percent over the number in 2019.

There is no reason to believe that New South Wales will be different. From 2002 to 2019, over 22,000 people have been officially euthanized in Belgium. (The real number is probably much higher because many Belgian doctors do not report cases of euthanasia). Currently around 5 percent of deaths in the Netherlands are by euthanasia and, if current trends continue, this number will increase very substantially within a few years.

This is hardly surprising; once we step over the clear line that we must not intentionally inflict death, there is no logical stopping point.

Good palliative care undermines the case for euthanasia

Most people have a very poor understanding of palliative care. Apart from relieving physical pain, good palliative care can deal with the three most common reasons for requesting euthanasia: feelings of loss of dignity, of loss of independence, and of being a burden on others. Many people believe that pain is the most common reason that people ask for euthanasia, but pain is well down on the list.

Dr Harvey Max Chochinov, a Canadian psychiatrist specializing in the care of terminally ill patients, has developed a psychotherapeutic intervention called “dignity therapy”. Trained carers can use these strategies with obvious success. Helping the terminally-ill person to review and record their life story to leave as a record for future generations of their family gives them back a sense of their own worth and hope.

Hope is the oxygen of the human spirit. Without it, our spirit dies; with it we can overcome even seemingly insurmountable obstacles. Dying people cannot have long-term hopes, but they can be given mini-hopes that make life worth living, that reignite their will to live. Common examples are of a person not dying until after their first grandchild is born or a beloved grandchild is married or graduates from university or an old friend from faraway is coming to visit. It is not uncommon to hear palliative care professionals say that many terminally ill people seem to choose when to die a natural death.

Helping dying people to find hope and meaning can sometimes be difficult and require skilled carers interacting with both the dying person and their loved ones, which is one reason easy access to high quality palliative care is so important.

Dr Chochinov speaks of a psychological state he calls “hopelessness” as being the trigger for the person seeking medical assistance to end their life. Professor David Kissane, an Australian specialist palliative care psychiatrist, has identified a similar condition he calls “demoralization” with its accompanying loss of the will to live.

Euthanasia despairs of reviving hope and finding meaning; instead, it eliminates the person.

Obligations to future generations: Euthanasia and climate change

Our obligation to future generations is a commonplace of euthanasia and climate change debates. Climate change threatens our physical ecosystem. Euthanasia threatens our socio-cultural (metaphysical) ecosystem, the collection of values, beliefs, attitudes, stories and so on that we buy into to create the glue that binds us together as a society. Neither ecosystem is indestructible; both can be irremediably damaged.

Most MPs in this Parliament will not live long enough to experience the worst effects of climate change – but their children will. Likewise for euthanasia. The question is not how will it affect me and our present society, but what kind of world will we bequeath to future generations?

What message does legalizing euthanasia send to fragile elderly people and people with disabilities? It is that they have “lives not worth living” or, even more reprehensibly, that they, themselves, do not have any worth.

What will be the effects on healthcare institutions and professionals? The medical literature testifies that many professionals have been psychologically traumatised by carrying it out, some even developing PTSD. The Dutch Medical Society has recognised this problem and has recommended, where possible, the use of assisted suicide rather than euthanasia.

Moreover, what about respect for freedom of conscience of healthcare professionals and institutions who believe euthanasia is unethical? This is already a major field of conflict among a wide variety of people and institutions.

Conclusion: a momentous decision

Euthanasia is one of the two most momentous values decisions of the first half of the 21st Century. (The other is whether to allow the use of new molecular biology and genetic science and technologies to design our children and their descendants.)

We must remember – painfully – that our own grandparents used human dignity-denying legislation, that we see today as constituting serious breaches of fundamental human rights, to achieve what they perceived as a “greater good”. At the time it was enacted, it was thought to be necessary and, we can only presume, ethical and beneficial to the people subjected to it. However, it did great harm and, revisited with wiser, future eyes, was repealed.

A prime example is the eugenic legislation of the 1920s and 1930s in Canada. Alberta and British Columbia passed “sexual sterilization” acts, which were only repealed in the 1970s. These allowed a Board appointed by the Government to authorise the sexual sterilization of institutionalized people, including children and people who were mentally incompetent.

Another powerful example is the laws that authorized and promoted the separation of First Nations children from their families and the “stolen generations” in both Australia and Canada in order to assimilate them into the dominant White Anglo-Celtic culture. The first of these was enacted in Victoria in 1869, with Queensland following in 1897. They were not repealed until 1969. It is noteworthy that, as with euthanasia legislation, Victoria led the way.

Precisely because the other states have legalized euthanasia, it is of critical importance that NSW refuses to do so. At least then, among many other reasons, fragile and vulnerable people can find a safe refuge in Australia and we will still have a jurisdiction that avoids the serious risks and harms of euthanasia.

For all our sakes, both those who are dying now and those who are not yet dying, and for our descendants and their future societies, we must kill the pain and suffering of dying people, not the dying people with the pain and suffering.

I urge you in the strongest possible terms to advise the NSW Parliament against enacting the *Voluntary Assisted Dying Bill 2021.*

Respectfully submitted,

Sydney NSW

15th November 2021

Appendix A encl.

Appendix B encl.

Appendix A

Short biography of Margaret Anne Ganley Somerville, AM, DSG, FRSC, DCL

Margo is Professor of Bioethics at the University of Notre Dame Australia, and at McGill University, Montreal, Emerita Samuel Gale Professor of Law, Emerita Professor in the Faculty of Medicine and Emerita Founding Director of the Centre for Medicine, Ethics and Law.

Professor Somerville graduated in Pharmacy (University of Adelaide, 1963), Law (First class honours and University Medal, University of Sydney, 1973), and Doctor of Civil Law degree (McGill University, Montreal, 1978).

She has received eight honorary doctorates, was the first recipient of the *UNESCO Avicenna Prize for Ethics in Science* awarded by an international jury, has an extensive national and international publishing and speaking record and is a frequent commentator in all forms of media. She is the author of over 900 articles, and four books: *The Ethical Canary: Journeys of the Human Spirit* (Viking/Penguin 2000) and *Death Talk: The case against euthanasia and physician-assisted suicide* (MQUP, 2nd ed., 2014). Her 2006 CBC Massey Lectures were published as *The Ethical Imagination: Journeys of the Human Spirit* (Anansi 2006) and her most recent book is *Bird on an Ethics Wire: Battles about Values in the Culture War s* (MQUP 2015).

Among many other honours and awards, Professor Somerville received the Order of Australia (1991) for her contribution to Bioethics, became a Fellow of the Royal Society of Canada (1990), and was made a Dame of the Order of Saint Gregory the Great by Pope Francis (2020).

Appendix B

Submission to the

NSW Legislative Council's Standing Committee on Law and Justice

Inquiry into *Voluntary Assisted Dying Bill 2021*

November 2021

QUESTIONING THE WISDOM OF LEGALIZING EUTHANASIA

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Introduction[1]

The COVID-19 virus pandemic is a threat to our physical and mental health and wellbeing, as both individuals and societies.

The Euthanasia "virus" pandemic is, likewise, a threat to our physical and mental health and wellbeing, as both individuals and societies. Most seriously, it is a threat to our "human spirit", the intangible, invisible, immeasurable reality that all of us need to find meaning in life and to make life worth living.

In other words, the "human spirit" is that deeply intuitive sense of relatedness or connectedness to all life, especially other people, to nature, the world, the universe and the cosmos in which we live. It gives us access to the metaphysical reality we need to experience to flourish and to live fully human lives. The "human spirit" does not require a belief in the supernatural. Everyone has and needs to be in contact with their "human spirit", whether or not they are religious (Somerville, 2008, pp. 7-9; 56-57).

Like the COVID-19 virus, euthanasia seems to be contagious, at least in postmodern, Western democracies. (Note: I use the word euthanasia to include medically assisted suicide.) Jurisdiction after jurisdiction has considered or is considering its legalization, although some have expressly rejected it, at least so far, most notably, the United Kingdom (Assisted Dying Bill [HL] (UK)) and France (Dungelhoff, 2021). From one perspective, this spread is not surprising, because we know that suicide is contagious (see, for instance, Robbins and Conroy, 1983; Romer, Jamieson, and Jamieson, 2006; Abrutyn and Mueller, 2014). In fact, general suicide rates - that is, exclusive of euthanasia - have risen in most and possibly all jurisdictions, which have legalised euthanasia (Boer, 2020).

As well, there is a well-established pattern, as we have seen in Australia, of pro-euthanasia advocates returning to legislatures and courts, time after time, until they achieve their initial goal of the legalization of euthanasia.[2] Subsequently, as can be seen in the Netherlands, Belgium and, most recently, Canada, pro-euthanasia advocates persistently seek reduction or even abolition of the requirements for its availability, that is, the initial safeguards,

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[1] This text has its origins in an article I was invited to write for *Eureka Street* magazine (Somerville, 2021b).

[2] For example, the South Australian Parliament had 17 Bills in 25 years before euthanasia was legalized in June 2021 (Mullins, 2021).

and expansion of the people who may have access to it (Canada opens door to expanding assisted dying, 2020).

In order to stem the Euthanasia pandemic, those of us who view this as a history making disaster and human tragedy must understand how it has arisen and where it is going. To do that we need to ask and seek answers to a multitude of questions. I can only very briefly mention a few of them here. I have spent over four decades researching and writing on them and still have many to address and new ones constantly emerge (see, for example, Somerville, 2014; Somerville, 2015; Somerville 2019b; Somerville, 2021a). We can think of this research as searching for an “anti-euthanasia vaccine”.

Before I do that, however, I want to emphasize that the people on both sides of the euthanasia debate are well intentioned and believe they are fighting for the greater good, it is just that we do not agree on what that is.

None of us on either side wants to see people suffer and the euthanasia debate is not about *if we will die* – we all will at some point. The debate is about *how we will die* and whether some ways of dying, namely euthanasia, are unethical and dangerous, especially to vulnerable and fragile people, and destructive of important shared values on which we base our societies.

PART 1. UNDERSTANDING the EMERGENCE of EUTHANASIA:

i) How can we best understand the “euthanasia pandemic”?

I propose that, as with research to help us to deal with the COVID-19 pandemic, we need to take a “questioning approach” to understanding the euthanasia pandemic. This means we should start our exploration of it by asking the many questions, which could provide us with insights that will lead to understanding why this pandemic has erupted and, thereby, how we might best deal with it. In the following text, I identify some of those questions.

ii) Why now do people support legalizing euthanasia?

People have always become ill, suffered and died and, for millennia, our laws have expressly and clearly prohibited killing them, especially having doctors, who promise in their Hippocratic Oath “to cure where possible, care always and never to intentionally kill”, doing so. So why now, when there is so much more we can do to relieve pain and suffering, is euthanasia thought to be necessary and a good idea? (Somerville, 2014, ch. 6).

There is a perfect storm of causes functioning at all the levels of decision-making from that of individuals in relation to their own experience of suffering, to that of governments formulating health policy and social and public policy.

iii) Why has the pro-euthanasia case been so successful and the anti-euthanasia case so unsuccessful?[3]

The case for legalizing euthanasia is *easy to make* in contemporary post-modern Western democracies, especially those in which moral relativism and utilitarianism are the main philosophies informing the dominant worldview of a society.

Moral relativism takes a stance that nothing is absolutely or inherently wrong, rather what is right or wrong all depends on the circumstances and the individual person's preferences. Utilitarianism in the context of euthanasia proposes that euthanasia is a means that has an outcome or end goal of reducing or eliminating suffering and, therefore, can be justified and is ethical. The discussion and analysis of the impact of legalizing euthanasia is limited to only the present time – I call this restriction "presentism" – and its impact on the individual person who seeks it. What we could learn from our "collective human memory" [4] (the past or history) and through employing our "collective human imagination" (the likely future outcomes of legalizing euthanasia) are ignored or rejected as irrelevant or invalid considerations.

In postmodern societies, so-called "progressive values" have become ubiquitous. These values favour legalizing euthanasia and dominate the more traditional or conservative values, which oppose that. The progressive values advocates' mantra is, "*control, choice, change*" (Somerville, 2019a, p. 47).

Control. In the context of euthanasia, control translates to taking *control of death*. We cannot avoid death, but euthanasia allows a person to get it, before it gets them. This eliminates uncertainty about the time, place and manner of death. It is psychologically difficult to live with uncertainty about outcomes that we dread, including because we do not know which psychological coping mechanisms we need to employ to deal with the fear we experience in anticipating those outcomes.

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[3] The response to this question is an edited version of Somerville, M. and Wesley Ely, E. (2021). The online edition of the volume in which that forward appears is available free of charge here.

[4] John Ralston Saul (Saul 2005) coined this term for history.

Taking control is what social psychologists call a “terror-reduction” or “terror management” device (Greenberg, Sheldon, and Pyszczynski, 1997; Greenberg and Arndt, 2012). Intense fear of death can be linked to a fear of mystery, the latter of which evokes profound free-floating anxiety. People who experience this can deal with their fear and anxiety by converting the mystery to a problem and seeking a technological solution to the problem. The mystery of death becomes the problem of death and the technological solution is a lethal injection – euthanasia.

Choice. Euthanasia is justified by its advocates claiming a *right to choose* to end one’s life, an overriding right to individual autonomy. “Intense or radical individualism” means the right to self-determination is given priority over any other considerations, such as what protecting the “common good” requires or the risks and harm to vulnerable people, such as fragile elderly people or those with disabilities. These harms include that euthanasia sends a message to them that they have “lives not worth living”.

Change. To have control and be able to choose death, the law must be *changed* to permit euthanasia (Somerville, 2015, ch. 4). Advocates have a naïve view that change is always for the better.

The pro-euthanasia case is promoted and buttressed by stories of “bad” natural deaths – those where great suffering is experienced – and “good” euthanasia deaths - those where suffering is promptly and completely eradicated through the intentional extinguishing of life, itself, by using euthanasia. The media, which overall has a bias towards legalizing euthanasia, are especially prone to presenting euthanasia as a topic for discussion in the public square in this manner. That is their reporting focuses on an individual suffering person and only takes into account the immediate impact in the present of providing that person with euthanasia (Somerville, 2015, ch. 4; Somerville, 2019a).

The case against euthanasia is much more difficult to promote, not because it is weak – it is not – but because it is much more complex.

To convince people, who do not believe that euthanasia is inherently wrong, to reject it, requires looking, not just to the present, but also to our “collective human memory” for lessons from the past and to our “collective human imagination” to try to anticipate the full, wider and long-term consequences of legalizing euthanasia.

Many non-Indigenous Australians, especially younger ones, are increasingly recognising how fortunate they are to have the over sixty thousand year old Aboriginal culture, the world's oldest continuous culture, from which to learn about seeking wisdom by looking to the past and to the future and not just the immediate present. Likewise, as Indigenous Australians also teach, we must consider both individuals and the "mob", the "common good. Nowhere is this more important than in relation to decisions about legalizing euthanasia. (*Finishing Up Business* (2021).

Politician and Aboriginal Elder Senator Patrick Dodson has made an outstanding contribution in this regard. His speech to the Australian Commonwealth Parliament opposing repeal of the law that prohibited euthanasia in the Northern Territory will sound down future generations (Dodson, 2018). Likewise, the scholarship of retired Catholic priest and archaeologist Eugene Stockton is a unique contribution. It helps us to understand the role that Aboriginal spirituality could play in enriching our ethical consciousness in 21st Century Australia (Stockton, 2015).

In short, while the individual person and their wishes and respect for their right to autonomy are always important considerations, they are not alone sufficient considerations, if we are to make wise decisions as a society with respect to the legalization of euthanasia or, if legalized, its governance. That requires, for example, taking into account the immediate and long-term, wider ramifications of authorizing physicians, and in some cases nurses[5], to end the life of another person through administering lethal medications with a primary intention to cause death.

These ramifications include the effects on healthcare professionals and the healthcare professions; on the institutions in which they practice, such as hospitals and aged care homes; on society and the shared values on which it is based and which create the glue, which bonds us as a community; and even on our global reality. There is a dearth of literature in these regards. A 2020 book, *Euthanasia: Searching for the Full Story: Experiences and Insights of Belgian Doctors and Nurses* (Devos, 2020), recounting stories from frontline healthcare professionals in Belgium where euthanasia has been normalized as a way to die, makes an important contribution to starting to fill these lacunae.[6]

Of particular concern in relation to the wider impact of legalizing euthanasia is the possibility of its being "thrust on" or "seeping into" the lives

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[5] The Canadian MAiD legislation allows this.

[6] A free open online reference to this text is available here.

of fragile and vulnerable people – those who are poor, uneducated, or least vocal. For example, doctors in Belgium have admitted to euthanizing people in a coma on a ventilator, without any family present to defend their best interests (Pereira, 2011, p. 39; Chambaere et al., 2015). We cannot afford to trivialize or underestimate the dangers of the abuse of legalized euthanasia, especially in relation to vulnerable and fragile people.

The Australian Law Reform Commission in its research and report on Elder Abuse (Australian Law Reform Commission, 2017) found and emphasized this danger. It concluded that between 4 and 14 percent of elderly people are abused, most often by a close relative. The Commission was concerned in particular about "early inheritance syndrome", where a person, usually a child of the elderly person, obtains a power of attorney and uses the financial assets of their parent for themselves. Many people worry about the cost of residential care for their elderly relatives and presumptive heirs see "their" inheritance, to which they feel entitled, dissipating. Imagine adding euthanasia, "early death syndrome", to "early inheritance syndrome" – it would certainly be a lethal cocktail.

We must also keep in mind that in a secular society, such as Australia, law and medicine carry the value of respect for life for society as a whole. Euthanasia destroys their capacity to do that because the law is changed to allow intentionally taking life and medicine implements that permission in practice. If euthanasia is legal, it should be kept out of medicine and a new profession created to undertake it (Boudreau and Somerville, 2014). Euthanasia is not medical treatment and it should have no role in palliative care (Sprung et al., 2018, p. 200). Indeed, the philosophical bases of palliative care – to live as well as possible until we die a natural death - and euthanasia - to choose death, rather than life - are in direct conflict.

It is also essential to recognize that the value of respect for life must be upheld at two levels: for the life of each individual person and for human life, in general, in society. Euthanasia damages respect for life at both these levels.

PART 2. FACTS or "POST-TRUTHS":

i) What are the correct facts about legalized euthanasia?

Good facts are essential for good ethics and good ethics for good law. This means we must ask, what are the correct facts about euthanasia?

ii) Are pro-euthanasia advocates correct that euthanasia will be rarely used and there is no danger of "slippery slopes"?

Euthanasia advocates often propose that euthanasia will be rarely used and only as a last resort. Let us look at some recent Canadian statistics:

> "As of April 30, 2021 there has been 7549 reported assisted deaths in Ontario since legalization [in June 2016]. 7547 were euthanasia deaths (lethal injection) and 2 were assisted suicide deaths (lethal prescription)" (Schadenberg, 2021).

This is very important information that cries out for in-depth research. What could this astonishing disparity in numbers between euthanasia and assisted suicide tell us? It is noteworthy that, so far, in the American states, which have legalised physician-assisted suicide, but have not allowed euthanasia, the number of such suicides are orders of magnitude below the Canadian statistics (Oregon Health Authority, 2018; Komrad, 2018). Might the explanation for the very high Canadian numbers include that euthanasia masquerades as medical treatment and we trust doctors and assume they are acting ethically and only doing good? To wisely judge the acceptability of euthanasia, we must take the medical cloak – the "white coat" - off it (Boudreau and Somerville, 2014, p. 7).

Then there are the claims of pro-euthanasia advocates that legalizing euthanasia does not open up "slippery slopes". Let us look again at Canada's experience:

> "The number of assisted deaths has been continually increasing in Ontario. There was a 33% increase in 2020 with 2378 reported assisted deaths, up from 1789 in 2019, 1499 in 2018, 841 in 2017, and 189 in 2016. Euthanasia was legalized in June 2016. Ontario euthanasia deaths have increased, in spite of COVID lock-down. …[There have been] 24,000 estimated assisted deaths in Canada since legalization" (Schadenberg, 2021).

The *Second Annual Report on Medical Assistance in Dying* has just been released by Health Canada and it gives the total number of MAiD deaths since the legislation came into effect, as 21,589 (Health Canada, 2021). In 2020, 2.5 percent of all deaths in Canada were by MAiD and there was a 34.2 percent increase over 2019 numbers. Again, these statistics show that euthanasia will not be used only rarely and is very quickly normalized, that is, the number of cases of euthanasia that occur once it is legalized, rapidly increase in a very short time.

This is not surprising. Once we step over the clear line that we must not intentionally inflict death, there is no logical stopping point. From 2002 to 2019, over 22 thousand people have been officially euthanized in Belgium (Statista, 2020) and the real number is probably much higher. Currently around 5 percent of deaths in the Netherlands are by euthanasia (Borasio, Jox, and Gamondi, 2019, p. 982) and, if current trends continue, this number will increase very substantially within a few years (see, for example, Belgium gives kids right to die, 2014).

The normalization of euthanasia and its frequent use, also opens up the unavoidable "logical slippery slope", that is, once euthanasia is legalized the situations in which it is available and the people who may access it rapidly expand. Indeed, there is now discussion in Canada whether all restrictions on access to euthanasia should be abandoned. The argument is that the justification for euthanasia is respect for the individual's right to autonomy and self-determination with regard to their own body and life and this right should not be limited (*Rodriguez v. British Columbia (Attorney General)*, 1993; Somerville, 2015, ch. 4). We can also see this justification being put forward in the Netherlands where the government is considering proposals that being "over 70 years of age and tired of life" or feeling that one has "a completed life" should be sufficient grounds to provide the person with access to euthanasia (Boztas, 2020).

The pattern is that legislators who first approve euthanasia do so with "strict safeguards", but these are quickly dropped and the people who can have access and in what conditions are greatly expanded.

As is already the case in the Benelux countries, Canada has now deleted from the MAiD (Medical Aid in Dying) legislation a requirement that "death be reasonably foreseeable". It did this, on the grounds that it discriminates against people with serious disabilities, who are not terminally ill and want euthanasia (*Truchon and Gladu v Attorney General (Canada) and Attorney General (Quebec)*, 2019; An Act to amend the Criminal Code (medical assistance in dying), 2021).

In 24 months' time, the law will allow people with serious mental illness, but no physical illness, to access euthanasia (An Act to amend the Criminal Code (medical assistance in dying), 2021). As American psychiatrist Dr Mark

Komrad succinctly commented, “The proper role of a psychiatrist is to prevent suicide, not to provide it” (Komrad, 2021).

The Canadian Parliament is also currently considering whether to amend the MAiD legislation to allow people with early dementia to give “advance directives” consenting to euthanasia to be carried out when they are incompetent to consent (Nakanishi, Cuthbertson, and Chase, 2021, p. 82).

Moreover, whether some children should have access to euthanasia is also under consideration and some healthcare professionals at the renowned Toronto “Sick Kids” Hospital have already drafted and published a protocol to govern this were it to be legalized (DeMichelis, Zlotnik Shaul, and Rapoport, 2019, p. 60).

It had long puzzled me how pro-euthanasia advocates could constantly deny that there was any “logical slippery slope”, when faced with such evidence. I had the opportunity to ask Andrew Denton, of the euthanasia advocacy group *Go Gently Australia*, about this, when we were on a panel together at a Victorian Australian Medical Association meeting in Melbourne. He explained that there was no “slippery slope” if the extension was a good and welcome development, rather, it would only be present if that were not the case. In short, “logical slippery slopes” are not of concern to pro-euthanasia advocates; rather, they are an inherent component of their platform.

Examples of the “practical slippery slope”, that is, once euthanasia is legalized it is provided not in accordance with the law, are legion. One study of doctors in the Flanders region of Belgium who had euthanized patients found that, by their own admission, 27 percent had done so on at least one occasion not in accordance with the law (Chambaere et al., 2010, see also Pereira, 2011; Chambaere et al., 2015). When this evidence is presented in other jurisdictions pro-euthanasia judges and politicians reject its relevance to their jurisdiction, by claiming that “our doctors are not like Belgium doctors”.

In summary, even though they might lose the battles against legalizing euthanasia, the work of people who oppose euthanasia is not over. They must now work to prevent its expansion and abuse.

iii) Who suffer and need support when a loved one is dying?

When a loved one is dying, not only the dying person can suffer, but also those close to them. Much of the patient’s suffering can be ameliorated with fully adequate palliative care and even those who have asked for euthanasia may change their minds in that regard, when provided with such care (Chochinov, 2020, ch. 1).

It is appalling that a very large percentage of people, who need and could benefit from palliative care, do not have access to it - for example, studies have shown that is true for up to 70 percent of such people in Canada (Canadian Institute for Health Information, 2018) and, likewise, Australia (Australian Government Department of Health, 2019). Especially if we believe that legalizing euthanasia is a terrible mistake, we must work to make high quality palliative care readily available.

Without access to good palliative care, accompanying a dying loved one can be a very traumatic experience, especially if they are in serious pain and there is poor pain management. It is easy to imagine that euthanasia could seem an attractive option in such circumstances. To remedy this situation, in 2010 the *Declaration of Montreal* (2010) was promulgated at a meeting of the *International Association for the Study of Pain* (IASP) (IASP 2010). It provides that for a healthcare professional knowingly and unreasonably to leave a patient in serious pain is a breach of fundamental human rights. The World Health Organisation (World Health Organisation, 2020) and the World Medical Association (Brennan, Lohman, and Gwyther, 2019, p. 63) have endorsed this approach, as have many national Pain Societies, including Pain Australia (Pain Australia, 2018).

Despite how it is described by its advocates, euthanasia does not necessarily avoid the problem of the suffering of loved ones of the dying person. Accompanying a person we love who is dying through euthanasia can also be a very traumatic experience, as I witnessed firsthand.

I have a friend in Toronto whose long-term partner, a specialist physician, was diagnosed with inoperable metastasized cancer. He arranged for a physician friend to come to his and my friend’s home to euthanize him only days after his being told that he was terminally ill. She and I were having lunch in a busy Bistro and she started to speak of her partner and his death. Suddenly she burst into uncontrollable sobs and kept repeating, “It was horrible, it was horrible! I couldn’t stay with him! I ran out of the room!”. I was shocked, because she is a highly respected professional woman, known for her strong emotional control in difficult circumstances, and is adamantly secular. She was clearly deeply traumatised by witnessing the euthanasia of her partner. The book referred to previously, *Euthanasia: Searching for the Full Story,* recounts many similar narratives.

In short, euthanasia is not necessarily the "rosy picture" death its advocates portray it as being.

iv) What is the impact of "time compression" on how we die?

We live in a world in which we expect instantaneous outcomes, we are not prepared to watch and wait. We have become "human doings", obsessed with what we can achieve in the shortest possible time, rather than seeing ourselves primarily just as "human beings", grateful for being alive. Life can be seen as no longer worth living, when we are no longer fit and healthy "human doings". Euthanasia reflects this belief, which is one reason legalizing it is of such great concern to fragile elderly people and those with disabilities.

Another important reason is, however, that some experiences cannot be time compressed without destroying their essential essence, which they can provide to those open to experiencing that. Yet again, the book *Euthanasia: Searching for the Full Story* (Devos, 2020) and another called *Dignity Therapy* (Chochinov, 2012)*,* which I discuss below, powerfully demonstrate that dying is such an experience and not just for the dying person, but also for those who love them. Yet again, Aboriginal Australians have much to teach us in this respect. They speak of the importance for the terminally ill person to have the necessary time at the end-of-life for "finishing up business"(Finishing Up Business 2021).

Has our focus on rights to autonomy and "radical individualism" blinded us to the importance for humans of relationships and, possibly, nowhere more so than when we are dying? We seem to have a primal fear of dying alone and it is very common to hear people say they want someone they love to be holding their hand when they die. We want to be accompanied in our leaving of this world. We hope to die in a loving relationship.

There is a beautiful story told by an Australian Palliative Care physician, Dr Frank Brennan, about the death of one of his patients, when he was working in a palliative care unit in Dublin Ireland, which captures dying in such a relationship.

Dr Brennan was caring for a dying man, whose wife had been constantly by his bedside. She looked completely exhausted. Dr Brennan said to her, "I know you've been here all the time. It might be good to go and have a rest, even just for a little while." After a long silence, she replied, "No. I'll not be leaving him". She then reminisced on her and her husband's life together, which included rearing seven children. Dr Brennan says she "spoke of a love that was boundless, a union that was indissolvable and … gave us a momentary glimpse into the mystery at the heart of it all" (Brennan, 2011).

v) Why is euthanasia euphemized?

In short, I believe it is because people do not want to face the reality of what is being done, intentionally killing a human being. We have natural inhibitions against killing other humans (Livingstone Smith, 2011). Advocates of euthanasia even object to the words "assisted suicide", arguing physician-assisted death is not suicide, and to euthanasia, saying it has harmful connotations and associations (Manns, 2017). They use terms such as *Voluntary Assisted Dying* (Victoria) (Voluntary Assisted Dying Act, 2017) or *Medical Assistance in Dying* (Canada) (Criminal Code (Canada), 1985, s. 241) and reduce those to acronyms VAD and MAiD, respectively, which have even less negative emotional impact. In the same vein of whitewashing what is involved, they speak of euthanasia as "the final act of good palliative care" (Nielsen, 2014). The vast majority of palliative care professionals strongly reject the claim that euthanasia can be a valid component of this care. (Sprung et al., 2018).

Word changes can be subtle and nuanced. For instance, in promoting the legalization of euthanasia and physician-assisted suicide, euthanasia has become "physician assisted dying" or "a merciful act of good clinical care", that is, even any reference to death is dropped. When more words are used to describe something that already had a name, we should know that we are being manipulated and something is being concealed. That something is the intentional infliction of death (Somerville, 2016).

Words, descriptions and labels matter also because they activate or suppress many of our "human ways of knowing", such as examined emotions, moral intuition, experiential knowledge and common sense that recent research shows play an important role in decisions about ethics (Somerville, 2021a). Moreover, our choice of words is closely linked to whether we activate, what physician-ethicist Dr Leon Kass called the "wisdom of repugnance" to guide us (Kass, 1997).

Consequently, to argue, as I have on occasion, that "we cannot afford to have doctors killing their patients", evokes a storm of outraged protest from pro-euthanasia advocates. However, if that is not what euthanasia involves, what does it involve?

Likewise, any mention of what we might learn from the Nazi doctors and the warnings that history (human memory) can provide triggers furious opposition. This is the case, even when one can show articles in the New York Times in the early 1930s describing the introduction of euthanasia by the Third Reich in Germany, which recount eerily similar justifications of euthanasia to those put forward today by the pro-euthanasia advocates (see, for example, Associated Press, 1933; Cook, 2021).

Then the media's role in promoting euthanasia through its "woke washing" of words and the ubiquitous post-truth reality of the early 21st century must be taken into account (Somerville, 2019a).

Recently, I published an article hoping it might cause people to think differently about what euthanasia involves. The question I addressed was "Why, if one agrees with euthanasia, would they not support carrying it out by giving the person a general anaesthetic and removing their vital organs - heart, liver, lungs - for transplantation"? (Somerville, 2019b).

Euthanized people are used as organ donors in Belgium (Ball, Sibbald, and Truog, 2018, p. 910) and Canada is using such donors with their consent (Yazdani et al., 2017). In fact, it is reported that Ontario doctors notify the Ontario transplant authority in advance of planned euthanasia cases and the authority's representatives call the patient or family to ask for consent to donating their organs after death (Cook, 2020).

In these cases, the person is first euthanized and then, after they die, the organs are taken. In my article, I questioned why combining euthanasia and organ donation into the same act, that is, giving the person a general anaesthetic and carrying out the euthanasia *by removal of their vital organs*, which results in more viable organs, was not employed. Many people, including those who support euthanasia, reacted very negatively to this possibility and I explored the possible reasons for their reaction. They included that it would make organ donation seem horrific and cause people to reject donating their own organs after death.

I believe it was also that it causes us to we see directly, "unsugar-coated", what euthanasia involves – doctors killing their patients or, in milder terms, inflicting death on them.

vi) Why have so many politicians voted in favour of euthanasia?

We hear constantly from pro-euthanasia advocates that polls show that a sizeable majority of the public want euthanasia to be legalized (Wordsworth, 2015) and politicians might believe they have obligations in a representative democracy to act as their constituents want or perhaps be trying to win (or at least not lose) these people's votes. However, just because a majority votes for something does not necessarily mean that it is ethical. Democracy and ethics can diverge. Likewise, just because something is legal does not necessarily mean that it is ethical.

Whether the members of the public understand what they are agreeing to in supporting euthanasia is a further question, because surveys have shown that often they hold a mistaken belief that refusing life support treatment or its withdrawal or providing necessary pain or suffering management are euthanasia (Angus Reid, 2010). As we all do, they want these interventions to be available and believe that requires agreeing to the legalization of euthanasia. They are, however, not euthanasia and are already legal and, appropriately used with no primary intention to cause death, are ethical, indeed, treatment that is ethically required to be offered to the patient (Somerville, 2014, ch. 5).

Politicians are often reluctant to have to deal with matters that involve conscience and, for some people, religious belief, and when they must deal with these matters, they can want to get rid of them quickly and with the least conflict and publicity possible, especially if an election is looming. Such issues can create "no win" situations for politicians, because whichever position they take they will lose some voters because of their choice.

Or might politicians just "read the wind" and, if the polls show voters want legalized euthanasia and its legalization seems highly likely, they just go along with that, whatever their personal values or views?

All postmodern Western nations are currently in a period of uncertainty about the nature and sustainability of flourishing democracy and, hence, of the ethical basis on which political decisions should be made. This is especially the case when the decisions involve affirmation or rejection of fundamental shared values on which these societies are based. Respect for human life, arguably our most important fundamental societal value, is the value at stake in the legalizing euthanasia debate.

PART 3. ALTERNATIVES to EUTHANASIA:

i) How can we limit use or extension of legalized euthanasia?

In the final section, I will ask some questions that might suggest some possibilities regarding what people who believe legalizing euthanasia is a terrible error might be able to do to limit or discourage its use or extension.

If euthanasia is legal, what can we do to limit its use or extension? In other words, how might we achieve the goal of reducing to the minimum the number of people requesting euthanasia? In order to achieve that, we need to understand the reasons for their requests and to find ways to make those reasons no longer important to them. We also need to try to prevent extensions of the people who may access euthanasia and the abolition of safeguards, which restrict access to it.

ii) Why do people ask for euthanasia?

Many people believe that pain is the most common reason that people ask for euthanasia, but pain is well down the list (Chochinov et al., 1995).

The three most common reasons are feelings of loss of dignity, loss of independence and of being a burden on others (Chochinov, 2004; Chochinov, 2012, ch. 1). Palliative care research shows many ways to change these feelings. For example, Dr Harvey Max Chochinov, a Canadian psychiatrist specializing in the care of terminally ill patients has developed a psychotherapeutic intervention called “dignity therapy”. In a book of that name, to which I have referred previously, he explains how helping the terminally-ill person to review and record their life story to leave as a record for future generations of their family gives them back a sense of their own worth. It also generates hope, through eliciting a feeling that something of themselves will have a presence in the future.

Hope requires a sense of connection to the future. Hope is the oxygen of the human spirit. Without it our spirit dies, with it we can overcome even seemingly insurmountable obstacles (Somerville, 2008, pp. 234-240). Dying people cannot have long-term hopes, but they can be given mini-hopes that make life worth living – that reignite their will to live. Common examples are of a person not dying until after their first grandchild is born or a beloved grandchild is married or graduates from university or an old friend from faraway is coming to visit. It is not uncommon to hear palliative care professionals say that many terminally ill people seem to choose when to die a natural death.

iii) How can we help dying people find a “why to live”?

Dr Chochinov speaks of a psychological state he calls “hopelessness” as being the trigger for the person seeking medical assistance to end their life. Professor David Kissane, an Australian specialist palliative care psychiatrist, has identified a similar condition he calls “demoralization” with its accompanying loss of the will to live, as having the same effect of triggering requests for euthanasia (Robinson et al., 2016a; Robinson et al., 2016b).

These findings are consistent with the powerful insight of Nazi Concentration Camp survivor, Viktor Frankl, who, when asked how he helped other inmates to survive, famously quoted Friedrich Nietzsche. “Those who have a ‘why’ to live, can bear with almost any ‘how’” (Frankl, 1992, p. 84).

We all need to have hope and be able to find meaning in life, even when we are dying, indeed, especially when we are dying, if we are to have a “good death”. Euthanasia does not provide this, rather it eliminates the person and with that the possibility of finding hope and meaning. Helping dying people to find hope and meaning can be difficult and requires skilled carers interacting with both the dying person and their loved ones, which is one reason easy access to high quality palliative care is such an important safeguard against people choosing euthanasia.

Another reason, why easy access to high quality palliative care is very important is that without that it is not possible to give an ethically and legally valid informed consent to euthanasia. Informed consent requires that all the medically indicated treatment options and the risks, harms, benefits, and potential benefits of each, including of refusing all treatment, must be disclosed to the patient to obtain their valid informed consent to the procedure which they choose (Somerville, 1980, p. 808).

iv) Why is it important to recognise the potentiality of euthanasia?

The potentiality of legalizing euthanasia requires us to consider what kind of world we will have left for future generations. Might it be one in which no reasonable person would want to live? What message does legalizing euthanasia send to vulnerable people - fragile elderly people and people with disabilities? Is it that they have "lives not worth living" or, even more reprehensibly, that they, themselves, do not have any worth?

Paradoxically, legalizing euthanasia tells them that they lack dignity, when the pro-euthanasia case is that euthanasia is necessary to respect their dignity. Likewise, the argument of pro-euthanasia advocates that legalizing euthanasia is necessary in order to respect the human rights of people with disabilities, including fragile elderly persons, is a two-edged sword. We need to keep in mind an old saying in human rights law: "Nowhere are human rights more threatened than when we act purporting to do only good". Our sole focus on the good that we hope to achieve blinds us to the unavoidable risks and harms involved.

What will be the effects on healthcare institutions and professionals in the future of legalizing euthanasia? We already know that many professionals are psychologically traumatised by carrying it out, some developing PTSD (Stevens Jr, 2006). The Dutch Medical Society has recognised this problem and recommended, where possible, the use of assisted suicide, rather than euthanasia (Rietjens et al., 2009, p. 276).

There has been a massive increase in Belgium in the use of "terminal sedation"[7] (sometimes called "slow euthanasia"), where the patient is permanently deeply sedated until they die (Tännsjö, 2004). ("Terminal sedation" needs to be distinguished from "palliative sedation" which is justified pain and symptom management, when means other than sedation are not sufficient, and there is no primary intention to shorten life (Somerville, 2015, p. 145)).

Moreover, what about respect for freedom of conscience of healthcare professionals and institutions, who believe euthanasia is unethical? This is a major field of conflict among a wide variety of people and institutions (see, for example, Machado, 2005; Ziebertz and Ballin, 2015; Heneghan, 2016, Symons, 2016, and; Luxmoore, 2021).

Conclusion: a momentous decision

I have been pondering a great deal lately, on what we can do about stopping the "euthanasia virus" pandemic. What would vaccinate us, as both

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[7] This term is used in this sense in the Quebec euthanasia legislation An Act Respecting End-of-Life Care (2013). It merits noting that surrogate decision makers may consent to this form of euthanasia for an incompetent person.

individuals and societies, against it? I have concluded that it is useless saying it is wrong or unethical or even dangerous - although it is very dangerous - and that we need a completely different approach, including along the lines of what we have to lose as individuals and societies by legalizing it.

Recently, I tried this approach in lecturing to the various classes I teach on ethics at the University of Notre Dame Australia Medical School. We discussed the ethics of euthanasia and the wisdom or otherwise of legalizing it. A clear majority of the students – probably, at a guess, at least 80 percent – are “progressive values” adherents – that is, for them respect for individual autonomy almost always takes priority as being the ethically preferable option. To my surprise, I had reports back from several tutors that students had told them that they were pro-euthanasia, but had never considered the issues I had raised and were now reconsidering their position.

In short, we need indirect approaches, as well as direct ones and, for example, in influencing politicians we need to keep in mind that politics follows culture, so we need to change the culture.

Euthanasia is a very complex issue in terms of the forces that have led to the current situation, including such small yet hugely impactful changes as “time compression” – we expect everything to be instant. Applied to natural dying, which can take an extended period, euthanasia is the “quick fix”. I believe that the overall societal zeitgeist has activated the push for legalized euthanasia and we have to change that zeitgeist if we think, as I do, that legalizing euthanasia is a very, very bad idea.

I have written elsewhere that one step we need to take in order to move in that direction is to recover our sense of “amazement, wonder and awe” about both ourselves and our world (Somerville, 2021a). I believe that this experience will help to guide us ethically regarding what we should and most importantly should not do and the latter includes legalizing euthanasia.

I predict that History will see the decision whether to legalize euthanasia, as one of the two most momentous values decisions of the first half of the 21st Century. (The other decision is whether to allow the use of new molecular biology and genetic science and technologies to design our children and all their descendants, through alteration of the human germ line.)

We need a new iteration of the old virtue of Prudence, which can be re-named “wise ethical restraint”, and we need Hope and Courage.

For hope in relation to avoiding euthanasia, among other sources, I look to precedents for abolishing legislation, which, at the time it was enacted, was thought to be necessary and, I presume, ethical and beneficial to the people subjected to it, but that did great harm and, revisited with wiser, future eyes, was much later repealed.

A prime example is the eugenic legislation of the 1920s and 1930s in Canada, for instance, the Alberta and British Columbia "sexual sterilization" acts, which were only repealed in the 1970s. These allowed a Board appointed by the Government to authorise the sexual sterilization of institutionalized people, including children and people who were mentally incompetent (Kouri and Somerville, 1979).

Another powerful example are the laws that authorized and promoted the separation of First Nations children from their families, the "stolen generations" in both Australia and Canada, in order to assimilate them into the dominant White Anglo-Celtic culture of that era. The first such legislation was enacted in Victoria in 1869 and Queensland followed in 1897. Such laws were not repealed in all Australian states until 1969. (Australian Human Rights Commission, 2015). It is noteworthy that, as with euthanasia legislation, Victoria led the way.

Because all the other Australian states have now legalized euthanasia, it is of critical importance that NSW refuses to do so. At least then, among many other reasons, fragile and vulnerable people can find a safe refuge in Australia and we will still have a jurisdiction that avoids the many and various serious risks and harms of euthanasia.

To return to the euthanasia debate, for all our sakes, both those who are dying and those who are not yet dying, and for our descendants and their future societies, we must kill the pain and suffering of dying people, not the dying people with the pain and suffering.

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