Submission
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INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

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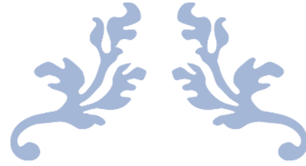

THE LAW AND JUSTICE COMMITTEE OF THE NSW LEGISLATIVE COUNCIL SUBMISSION ON PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

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Personal Introduction

Dr John I Fleming is a retired academic and Catholic priest. He is married with 3 children and 2 grandchildren. In a long academic career, he has been the Foundation Director of Adelaide’s Southern Cross Bioethics Institute, 1987-2004; a foundation member of UNESCO’s International Bioethics Committee which developed the Universal Declaration on the Human Genome and Human Rights (adopted by the General Conference of UNESCO on 11 November 1997), 1992-1996; Deputy Member of the Medical Practitioners Professional Conduct Tribunal under Section 24 of the Medical Practitioners Act 1983. (SA), 1998-2004; Member of the SA Council on Reproductive Technology. (SA Parliament), 1998-2004; and inaugural President of Campion College Australia, 2004-2009.

The material used in this submission is drawn from my just recently published and much larger work:

John Fleming, *To Kill or Not to Kill*, London, Austin Macauley Publishers, 2021

Executive Statement of Argument

In this submission I will try to avoid, as far as possible, repeating much of the standard approach to the subject. The essence of the argument I will pursue is this:

1. The public policy duty of parliamentarians to secure the peace in a liberal democracy as exemplified in the New South Wales Parliament (NSW) as formally constituted under its *Constitution Act 1902 No 32*.
2. NSW Parliament is duty bound to protect the "deeply rooted" human rights of its citizens and especially the rights to life and security of person.
3. The right to life is an inalienable right, a right of which innocent citizens cannot be deprived nor may they even deprive themselves of that right.
4. To legalise voluntary assisted suicide, and voluntary assisted dying (voluntary assisted suicide) undermines the capacity of the Parliament to protect equally and impartially the right to life of all citizens.
5. Individual citizens have different views about the morality of euthanasia and physician assisted suicide. The public policy issues here cannot be decided based on the personal morality of individual parliamentarians.
6. The empirical evidence of legalised medical killings in other jurisdictions world-wide indicates that many are killed without their knowledge and consent. This is evidence that no responsible parliamentarian can or should ignore in the light of the primary duty of parliament to secure equally and impartiality the lives of innocent citizens.
7. Compassion is the virtue impelling one to act to assist another once one knows what is the right thing to do. Appeals to *feelings* of "compassion" by themselves provide no safe basis for public policy decision-making
8. **Aquinas explained that compassion if just felt is not a virtue. To be 'moved by pity' is fine, but not if the movement is simply one of feeling. For this can cause more harm than good, practically and morally; if it is only felt, compassion may lead us to misjudge the evil or to respond to it inappropriately. By causing us to react inappropriately to suffering, feelings can make us unable to identify their cause correctly and so to intervene effectively. Genuine compassion requires feeling and the intellectual recognition that the suffering which causes this requires a practical and moral response, not just a knee-jerk response assuaging of our feelings.**[1]
9. Intervening feelings which influence decision making include the unhealthy identification with suffering leading to the psychological phenomenon of transference, the eugenic idea of the life no longer worth living and to whom that applies, and the feeling that some people are "better off dead".

It is my conclusion that there should be no exceptions to the universal law that it is always wrong to kill the innocent. This is true whether those exceptions to the law of homicide be any form of legalised euthanasia, and so-called but misnamed "voluntary assisted dying"' better described as physician assisted suicide. The Parliament should resist the temptation to undermine the fundamental duty of Parliament to protect equally and impartially all citizens in the face of emotional appeals to hard cases (mainly historical) or the false assertion that everyone has the "right to die" at the time of their own choosing. Such appeals would also undermine the many suicide prevention programmes to which we are already strongly committed.

> In the words of the House of Lords Select Committee on Medical Ethics (1995): "Ultimately, however, we do not believe that these arguments [in favour of legalised euthanasia] are sufficient reason to weaken society's prohibition of intentional killing … **That prohibition is the cornerstone**

[1] Dr Hayden Ramsay "St Thomas Aquinas on euthanasia in South Australia", *Bioethics Research Notes* 9(3): September 1997. Cf Thomas Aquinas, *Summa Theologiae*, 2-2, 30, 1-3

of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal … We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions ... **We do not think it possible to set secure limits on voluntary euthanasia** … It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused … **We believe that any decriminalisation of voluntary euthanasia would give rise to more, and more grave, problems than those it sought to address.**[2]

The voluntary assisted dying legislation should not be agreed to by the NSW Parliament if the Parliament is to properly fulfil its constitutional duties.

The arguments in detail

Protect peace and security of citizens: first duty of the Parliament

Parliamentary democracies such as that obtain in Australia are based upon the motion of the social contract which emerged in the 17th and 18th centuries. The first duty of parliamentarians is to make law to maintain peace by protecting citizens from threats of violence from foreign agents as well as from other citizens.

> **Hobbes is famous for his early and elaborate development of what has come to be known as "social contract theory", the method of justifying political principles or arrangements by appeal to the agreement that would be made among suitably situated rational, free, and equal persons.**[3]

John Locke further developed the idea of the social contract.[4]

Essentially both men (and Rousseau) began by considering 'man in the state of nature' where there was no government and each person determined for himself or herself what they would do. But human beings cannot live that way because in such a lawless situation the lot of man is 'nasty, poor, brutish, and short'. So human beings enter into a contract with a government. Individuals give up their right to do whatever they please and contract with a government to accept the laws enacted provided that the government protects the life and security of each human being and the security of the State from foreign attack.

So it is that the people of NSW have contracted through its Constitution to be ruled by the government which, in return, must guarantee the protection and security of the citizenry. Otherwise, as they say, all bets are off.

The NSW Constitution expresses it this way

> **The Legislature shall, subject to the provisions of the Commonwealth of Australia Constitution Act, have power to make laws for the peace, welfare, and good government of New South Wales in all cases whatsoever**[5]

And the Australian Constitution, adopted by the people of Australia by way of referendum, says this:

> **The Parliament shall, subject to this Constitution, have power12 to make laws for the peace, order, and good government of the Commonwealth**[6]

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[2] House of Lords, *Report of the Select Committee on Medical Ethics Volume 1-Report*, London, HMSO, 1994, 48-49

[3] *Hobbes's Moral and Political Philosophy*, 2018, at https://plato.stanford.edu/entries/hobbes-moral/; and see Thomas Hobbes, *Leviathan*, 1651

[4] John Locke, *Two Treatises of Government*, 1690)

[5] *Constitution Act 1902 No 32*, Part 2 Powers of the Legislature, clause 5, https://legislation.nsw.gov.au/view/whole/html/inforce/current/act-1902-032

[6] Section 51 of the *Constitution of Australia*

According to the High Court of Australia, under the Australian Constitution the limits of law-making in the various States includes the inability of any Australian State to abrogate "rights deeply rooted".[7] The High Court did not give great specificity to its discussion of this matter, but there is sufficient there for the NSW Parliament to see itself as committed to protecting impartially "deeply rooted" rights in the body politic, including the prohibition against us killing innocent human beings in any circumstance.

Deeply rooted rights- what are they?

Australia, like all other countries in the world committed itself to the *Universal Declaration on Human Rights 1949* (UDHR). The UDHR describes the recognition of fundamental human rights as the "foundation" of peace in the world and that they are derived from the **inherent dignity of all members of the human family**. The State does not grant or bestow fundamental human rights. The State must recognise the fact of those rights and protect them

> **Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,**[8] **[emphasis added]**
>
> **All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.**[9]

These human rights are equal and inalienable and apply to every member of the human family without distinction of any kind.

- Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth **or other status**. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.[10] [emphasis added]

> **Everyone has the right to life, liberty and security of person.**[11]

These fundamental or "deeply rooted" rights are universally held even if not universally practiced. By the end of 2000 AD there were 191[12] member states representing a total estimated population of 6,029,694,000 people[13]. The world population in 2000 was estimated to be 6,070,581,000.[14]

This means that about 99.3% of the peoples of the world belong to nations that are member states of the United Nations and are thereby committed, at least morally, to the Universal Declaration of Human Rights.

The UDHR (and the ICCPR) stand as the internationally agreed basis for the nations of the world to bring their own laws into conformity with the requirement to protect fundamental human rights.

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[7] This was found by the High Court of Australia to be the case in *Durham Holdings Pty Ltd v New South Wales* [2001] HCA 7 [2001] HCA 7; 205 CLR 399; 177 ALR 436; 120 LGERA 120. See in particular paragraphs 40, 72, and 74
[8] UDHR, Preamble
[9] UDHR, Article 1
[10] UDHR, Article 2
[11] UDHR, Article 3
[12] www.un.org/Overview/growth/html

[13] Ibid.
[14] esa.un.org/unpp/p2k0data.asp

What is an inalienable right?

An *inalienable right* is a right which cannot be violated, a right "unable to be taken away from or given away by the possessor."[15] Just as you cannot sell yourself into slavery (freedom being an inalienable right), so also you cannot give away your right to life.

Australian Parliaments cannot and should not legalise the killings of innocent persons even at their own request. That includes assisting a person to suicide. Each State Parliament and the Commonwealth is duty bound to protect impartially the *inalienable right to life* of all Australian citizens,

Why are these rights held to be "inalienable"?

Thomas Hobbes (1588–1679), rightly regarded as one of the political philosophers from the Enlightenment who most influenced modern human rights talk, described the law of nature as

> **a precept or general rule found out by reason, by which a man is forbidden to do that, which is destructive of his life, or taketh away the means of preserving the same; and to omit that, by which he thinketh it may best be preserved.**[16]

If fundamental human rights are not inalienable, if citizens are permitted to give up their fundamental human rights, then it undermines the ability of the government or the State to protect the fundamental rights of others, especially the weak and the vulnerable.

One such fundamental human right is *freedom*.[17] If individuals can give up their right to freedom and sell themselves as slaves, this undermines the ability of the State to protect the freedom of those who do not wish to be slaves and who will be drawn into slavery non-voluntarily. If we allow a pro-choice position on freedom, and individuals are given the legal "right" to sell themselves into slavery, then it follows that the slave trade must, to some extent, be legalised. Once that occurs, others, particularly the weak and the vulnerable, will be drawn into the slave-trade non-voluntarily. The State will not legalise the slave trade for those who may wish to enter it voluntarily, even for very compassionate reasons. Indeed, the slave trade and slavery are both explicitly required to be "prohibited in all their forms."[18]

It is the same with the right to life, another fundamental or "deeply rooted" human right described as inalienable. Legalised voluntary euthanasia involves a modification of the law proscribing homicide to allow the intentional killing of a patient by a doctor at the patient's request and out of a motive of compassion. Legal voluntary euthanasia involves an exception to the normal rule against the homicide of innocent human beings. When this occurs the State's capacity to protect the weak and the vulnerable from non-voluntary euthanasia is greatly compromised if not completely undermined. While the *Universal Declaration of Human Rights* does not exclude voluntary euthanasia by name as it does the slave trade and slavery, it does so by calling the right to life "*inalienable*" and including the right to life along with the right to "liberty and security of person" as fundamental inalienable human rights.[19]

Fundamental human rights are inalienable because once one allows them to be alienable (given or taken away) then the fundamental human rights of all are put at an unacceptable risk.

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[15] *Concise Oxford English Dictionary*, Oxford, Oxford University Press, 2011

[16] Thomas Hobbes, *Leviathan, or the Matter, Forme and Power of a Commonwealth Ecclesiasticall and Civil*, edited by M Oakeshott, Oxford, Blackwell, 1960, 84. This book was first published in 1651.

[17] Universal Declaration of Human Rights, Articles 3 and 4

[18] Universal Declaration of Human Rights, Article 4

[19] Universal Declaration of Human Rights, Article 3

Claimed unacceptable and unavoidable risks with legal euthanasia and physician assisted suicide or VAD?

Front and centre of the public policy debate on legalised VAD or any other form of euthanasia is the claim that we would be in danger of sliding down a slippery slope to non-voluntary matters often labelled as "slippery slopes". These dangers are expressed under two headings.

1. that despite the presence of legal safeguards, the practice of euthanasia and VAD always involves alongside of it the practice of non-voluntary killings; and/or
2. that legalisation of voluntary euthanasia and VAD for some cases will lead to calls for euthanasia and VAD for increasing types of cases, and especially for those who are not terminally ill such as those with dementia.

Belgium: empirical evidence of non-voluntary ending of human life

On the 17th of May 2010 another set of Belgian scholars reported their research on the use of life-ending drugs in the *Canadian Medical Association Journal*. These scholars asked Belgian doctors to fill out a questionnaire to see whether these drugs were ever administered to patients who had not requested them. Of the 208 deaths reported to them where the administration of life-ending drugs was involved:

> **142 were carried out *with* an explicit patient request (euthanasia or assisted suicide).**
>
> **66 patients were administered the drugs *without* an explicit request.**[20]

In this study we see that in nearly 32% of cases doctors admit to administering life-ending drugs without the consent of the patient.

Where life-ending treatment was carried out without explicit request, the matter had been discussed with 22.1% of the patients. The reasons given as to why the ending of life decision was not discussed with the remaining 77.9% of patients were:

1.	Patient was comatose	70.1%
2.	Patient had dementia	21.1%
3.	Decision was clearly in the patent's best interests	17.0%
4.	Discussion would have been harmful to patient	8.2%
5.	Other	10.1%[21]

On the 15th June 2010 the same journal published a study on the role of nurses in physician-assisted deaths in Belgium.[22] In this study there were 128 nurses who reported having had the care of a patient who received euthanasia, that is euthanasia carried out with the explicit request and consent of the patient. There were 120 nurses who had cared for a patient who received life-ending drugs without explicit request. The interesting thing here is that nurses administered the life-ending drugs only 12% of the time where voluntary euthanasia (full consent) was involved, but 45% of the time when there was no explicit request.

> **In both types of assisted death, the nurses acted on the physician's orders but mostly in the physician's absence.**

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[20] Kenneth Chambaere PhD, Johan Bilsen RN PhD, Joachim Cohen PhD, Bregje D Onwuteaka-Philipsen PhD, Freddy Mortier PhD, Luc Deliens PhD, "Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey", *CMAJ* 2010. DOI:10.1503/cmaj.091876, 1

[21] Kenneth Chambaere PhD, Johan Bilsen RN PhD, Joachim Cohen PhD, Bregje D Onwuteaka-Philipsen PhD, Freddy Mortier PhD, Luc Deliens PhD, "Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey", *CMAJ* 2010. DOI:10.1503/cmaj.091876, 4

[22] Els Inghelbrecht, Johan Bilsen RN PhD, Freddy Mortier PhD, Luc Deliens PhD, "The role of nurses in physician-assisted deaths in Belgium", *CMAJ* 2010. DOI:10.1503/cmaj.091881, 905

> **By administering the life-ending drugs in some of the cases of euthanasia, and in almost half of the cases without an explicit request from the patient, the nurses in our study operated beyond the legal margins of their professions.**[23]

The euthanasia law in Belgium requires physicians to discuss requests for euthanasia with nurses involved in the care of a patient. It seemed that doctors also discussed euthanasia with nurses when the patient was unable to make a request. What is particularly disturbing though, is that nurses are being ordered by doctors to kill patients outside of the confines of the law.

> **The administration of life-ending drugs by nurses, whether or not under the physician's responsibility, is not regulated under Belgium's euthanasia law and therefore not acceptable. In particular, when criteria for due care are not fulfilled, such as in cases where the patient has not made an explicit request, nurses, next to the physician, risk legal prosecution.**[24]

Do doctors in Belgium believe that the law always applies to them? Apparently not. It is the stated policy of the "Belgian Society of Intensive Care Medicine" (the Society) that the law doesn't always apply to them.

> **Moreover, we explain our belief in the concept that shortening the dying process by administering sedatives beyond what is needed for patient comfort can be not only acceptable but in many cases desirable.**[25]

Hiding behind euphemisms the statement describes administering a lethal injection as "shortening the dying process". In their statement the Society describes what it sees as a problem in these terms:

1. "Critically ill patients dying in the ICU are usually not in a position to request euthanasia."
2. "… forgoing futile treatment is not against current Belgian legislation …"
3. "As a result, in Belgium, there is uncertainty about the legal consequences of starting a process that will result in death in the ICU."[26]

The solution the Society provides is to allow its members to kill the patient. Here the Society is demonstrating its belief that as intensivists they are above the law, and that, with the support of the Society, are very unlikely to face prosecution.

This policy applies both to children as well as adults.[27] Relatives should be informed of the doctor's decision, but their permission to end the life of their loved one does not have to be obtained. Using familiar illogical argumentation, the Society states that what they are doing is "not be interpreted as killing but as a humane act to accompany the patient at the end of his/her life".[28]

There is a clear distinction between *motivation* and *intention*. In these cases, the *motive* may be the *feeling* of doing an "humane act", but nevertheless the doctor is *intentionally* and illegally killing his patient.

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[23] *Ibid.*
[24] *Ibid.*, 909
[25] Belgian Society of Intensive Care Medicine, ""Piece" of mind: End of life in the intensive care unit Statement of the Belgian Society of Intensive Care Medicine", *Journal of Critical Care*, February 2014, Volume 29, Issue 1, 174–175. One suspects that the use of the word "piece" in the title is meant to convey that the writers will get "peace of mind" by giving the authorities a "piece of their mind".
[26] Belgian Society of Intensive Care Medicine, ""Piece" of mind: End of life in the intensive care unit Statement of the Belgian Society of Intensive Care Medicine", i*bid.*
[27] "The present document applies to children as well as to adults." Belgian Society of Intensive Care Medicine, ""Piece" of mind: End of life in the intensive care unit Statement of the Belgian Society of Intensive Care Medicine", *Journal of Critical Care*, February 2014, Volume 29, Issue 1, 174–175
[28] Belgian Society of Intensive Care Medicine, i*bid.*, 174–175

The Netherlands: empirical evidence of non-voluntary ending of human life?

The first very extensive and thorough reports on euthanasia in the Netherlands were published in 1991. It is worth recalling what the situation was like in those comparatively early days of legal euthanasia and then comparing that with the situation in 2016.

In the year 2000 AD, the Dutch Parliament passed legislation to codify the practice of euthanasia as it had been allowed by the Courts from 1984. Doctors were legally obliged to report all cases of euthanasia. The reports must be made to a regional committee set up for the purpose and composed of a lawyer, a physician, and an ethicist/philosopher. Each position also has a deputy member. It is the role of the committee to evaluate each case of euthanasia.

Notwithstanding the fact that euthanasia was not passed into legislation until 2000 AD, it is not true that we have no statistical or empirical evidence of the way euthanasia was practiced once it becomes legally tolerated by the courts. The figures for the number of cases of euthanasia reported to the police in each year from 1984 are available such that in the 1990s we know that the number of cases reported to the authorities, in accordance with the law, increased from 454 in 1990 to 1322 in 1992 to 1424 in 1994.[29] These numbers do not account for the total number of cases of euthanasia, only those reported to the authorities and considered for prosecution. In most cases doctors had falsified the cause of death as being due to "natural causes". The reasons doctors gave for falsifications were:

1. to avoid the "fuss" of a legal investigation (55%);
2. a desire to protect a relative from a judicial inquiry (52%); and
3. a fear of prosecution.[30]

The survey of euthanasia practice carried out by the government in 1991 gave a much more revealing picture of what was going on. The work was carried out under the supervision of the Attorney-General, Professor Jan Remmelink. Paragraphs 4.4 - 4.5 of the Remmelink Report show that voluntary euthanasia is, in fact, accompanied by non-voluntary euthanasia.

The number of physician-assisted deaths estimated by the 1991 Remmelink Committee Report[31] was 25,306, all of which involved intentional (sometimes implicit, sometimes explicit) killing by act or by neglect, some voluntary and others non-voluntary. They are made up of:

2,300 euthanasia on request[32] [In the Netherlands euthanasia means voluntary euthanasia. If it is not voluntary it is not euthanasia]

- 400 assisted suicide[33]

1,000 life-ending treatment without explicit request[34]

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[29] From the table of disposals of euthanasia cases which appeared in the annual report of the public prosecutor, 1994 (Jaaverslaag Openbaar Ministrie 1994, Ministrie van Justitie, Den Haag, 1995) as it appears in John Keown, "Euthanasia in the Netherlands: sliding down the slippery slope?", in John Keown ed., Euthanasia Examined: Ethical, Clinical and Legal Perspectives, Cambridge, Cambridge University Press, 1995, 283, and ibid., footnote 159 on page 296

[30] John Keown, "Euthanasia in the Netherlands: sliding down the slippery slope?", in John Keown ed., *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, *op. cit.*, 275

[31] There were two reports published at the same time. *Medische Beslissingen Rond Het Levenseinde* - Het onderzoek voor de Commissie Onderzoek Medische Praktijk inzake Euthanasie, (The Hague, The Netherlands: Sdu Uitgeverij, 1991) [*Dutch Euthanasia Survey Report*] and *Medische Beslissingen Rond Het Levenseinde* - Rapport van de Commissie Onderzoek Medische Praktijk inzake Euthanasie, The Hague, The Netherlands: Sdu Uitgeverij, 1991) [*Remmelink Report*]. I am indebted to the late Dr Daniel Ch. Overduin for translating the relevant sections of the two reports, thereby making the detailed evidence contained in them accessible to the English-speaking but non-Dutch-speaking public.

[32] *Remmelink Report*, 13

[33] *Remmelink Report*, 15

[34] *Remmelink Report*, 15

- 4,756 patients died after request for non-treatment or the cessation of treatment with the intention to accelerate the end of life[35]
- 8,750 cases in which life-prolonging treatment was withdrawn or withheld without the request of the patient either with the implicit intention (4,750) or with the explicit intention (4,000) to terminate life[36]
- 8,100 cases of morphine overdose with the implicit intention (6,750) or with the explicit intention (1,350) to terminate life.[37] Of these 61% were carried out without consultation with the patient, ie non-voluntary euthanasia.[38]

This total of 25,306 deaths amounted to 19.61 per cent of total deaths [129,000] in The Netherlands in 1990. A large proportion of these deaths involved intentional (either implicit or explicit) killing by act or by neglect, ie euthanasia.

To this should be added the unspecified numbers of handicapped newborns, sick children, psychiatric patients, and patients with AIDS, whose lives were terminated by physicians, according to the *Remmelink Report*.[39] The narrow definition of euthanasia masks the real number of individuals whose lives are ended by interventions from the medical profession and masks the fact that more people are intentionally killed by physicians without their consent than with their consent.[40]

This situation is clear if we take only those cases from the Dutch evidence where the doctors were "acting with the explicit purpose of hastening the end of life."[41] This explicit intention or purpose is explained as follows: "If a physician administers a drug, withdraws a treatment or withholds one with the explicit purpose of hastening the end of life, then the intended outcome of that action is the end of the life of the patient."[42]

In short, "explicit" intent is synonymous with the natural (and legal) meaning of "intent" as purpose, goal or aim.[43]

Now, as we have seen, the Dutch evidence shows us that in 1990 there were 10,558 cases where there was an "explicit" intention to hasten the end of life by act or by omission. As John Keown has put it:

> **This total comprises the 2,300 cases classified as 'euthanasia' in the survey; the 400 cases classified as 'assisted suicide' in the survey; 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'.**[44]

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[35] There were 5,800 such cases, *cf ibid.*, 15. However only 82% [ie 4,756] of these patients actually died. *Cf Dutch Euthanasia Survey Report*, 63 ff

[36] There were 25,000 such cases, *cf ibid.*, 69. However, only 35% (8,750 cases) were done with the intention to terminate life. Cf *ibid.*, 72; cf also *Remmelink Report,* 16

[37] There were 22,500 patients who received overdoses of morphine, *cf ibid.*, 16.36 per cent were done with the intention to terminate life, *cf Dutch Euthanasia Survey Report*, 58

[38] *Dutch Survey Report*, 61, Tabel 7.7. ["Besluit niet besproken"]

[39] The Remmelink Report, 17-19

[40] Other reviews of the evidence from the two Dutch reports supporting the present writer's analysis may be found in Richard Fenigsen, "The Report of the Dutch Governmental Committee on Euthanasia", *Issues in Law & Medicine*, 7:3, 1991, 337-344; Henk A.M.J. ten Have and Jos V.M. Welie, "Euthanasia: Normal Medical Practice?" *Hastings Center Report*, 22:2, March-April 1992, 34-38

[41] P.J. van der Maas, J.J.M. van Delden, and L. Pijnenborg, *Euthanasia and other Medical Decisions Concerning the End of Life*, Amsterdam: Elsevier, 1992, 21

[42] *Ibid.*

[43] John Keown, "'Dances with Data': A Riposte", *Bioethics Research Notes*, 6 (1), 1994, 1

[44] John Keown, "'Dances with Data': A Riposte", i*bid.*

Simple mathematics shows that of the 10,558 cases where there was an "explicit" intention to hasten the end of life by act or by omission, 55% were non-voluntary. This justifies the conclusion that it is impossible to quarantine non-voluntary euthanasia from voluntary euthanasia, that where voluntary euthanasia is practised more are killed without their consent than with their consent.

In 1993 some of the authors of the 1991 Remmelink study accepted that voluntary euthanasia inevitably leads to non-voluntary euthanasia:

> **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.**[45]

Peter Hung Manh Tran noted that the Dutch Reports in 1991 concluded that the Dutch guidelines for carrying out euthanasia by a doctor

> **… are incapable of preventing abuse. The Survey bears out this conclusion by indicating that cardinal safeguards – requiring a request, which is free and voluntary; well informed; and durable and persistent – have been widely disregarded.**[46]

Dutch euthanasia continues to rise

If that was the case in 1991, how widespread is the practice of euthanasia in the Netherlands today?

It would be reasonable to suppose there would be more euthanasia once it is legalised because that is what legalisation is supposed to achieve. We are constantly told of all the cases of people who would have used euthanasia if it were legally available. Common sense tells us that there would be an increase in euthanasia upon legalisation. If it could be shown that voluntary euthanasia is always accompanied by non-voluntary euthanasia then the amount of abuse or harm would also increase, ie a slippery slope. But what do the facts reveal?

Reported euthanasia deaths 2006-2015

Year	Number of reported deaths due to euthanasia in the Netherlands	Percentage increase year on year
2006	1923	
2007	2120	10.24%
2008	2331	9.95%
2009	2636	11.57%
2010	3136	15.94%
2011	3695	17.82%
2012	4188	13.34%
2013	4829	15.31%
2014	5306	9.87%
2015	5516	3.95%

[45] Johannes J.M. van Delden, Loes Pijnenborg and Paul J. van der Maas, "The Remmelink Study Two Years Later", *Hastings Center Report*, November-December 1993, 26

[46] Peter Hung Manh Tran, *Advancing the Culture of Death: Euthanasia and Physician-Assisted Suicide*, Freedom Publishing Company, North Melbourne, 2006, 90

There has been a 186% increase in deaths from euthanasia in the Netherlands from 2006 to 2015, that is there are nearly three times the number of deaths each year from euthanasia from 2006 compared to 2015.

However, by 2016, the number of official cases of euthanasia in the Netherlands rose a further 10% from the previous year to 6091 with euthanasia now accounting for 4% of total deaths[47]. So, between 1990 and 2016 the cases involving legal euthanasia cases jumped from 454 to 6091, an increase of more than 1,250%.

John Keown has recently summarised the evidence of euthanasia as it is practised in the Netherlands today.

> **The Netherlands legalized VE/PAS[48] in 1984. Despite the legal requirement that physicians end life only at the explicit request of the patient and report all cases, six large-scale official Dutch surveys have disclosed that since 1984 physicians have, with virtual impunity, failed to report thousands of cases, and have given lethal injections to thousands of patients without request. Dutch assurances when the law was relaxed in the 1980s that euthanasia without request would not take place, and would be prosecuted as homicide if it did, have long rung hollow. In 2016 Professor Boer, a former euthanasia review committee member, observed that of 45,000 cases reported to the review committees since 2002 only 75 had been referred to the prosecutors for breaching the criteria and none had resulted in prosecution. The Parliamentary Report asserted: "Instances of assisted dying are rare, even in jurisdictions where it is legal." Rare? In the Netherlands in 2016 VE/PAS accounted for some 6,000 deaths or 1 in 25 of deaths from all causes. The Dutch government's proposals in 2016 to extend the law to allow elderly people with "completed lives" to access assisted suicide promises to lead to a further substantial increase in numbers, involving many people who could live for years.[49]**

Belgium: empirical evidence that once accepted in principle for hard case, the categories of eligible persons widen?

Since the passing of the law in 2002, there have been more than 20 draft bills submitted to the Belgian Parliament, mostly to extend euthanasia to other categories of individuals or to simplify the legal process.

On the 28th of February 2014, the Belgian parliament extended its euthanasia law to terminally ill children of any age subject to certain conditions. The conditions imposed on children said to be seeking euthanasia are:

1. the patient must be conscious of their decision and understand the meaning of euthanasia
2. the request must have been approved by the child's parents and medical team
3. their illness must be terminal; and
4. they must be in great pain, with no available treatment to alleviate their distress.

In addition, a psychologist/psychiatrist must be called to assess the patient's maturity to make the decision, and to ensure that the decision is voluntary. The amendment emphasizes that the patient's request be voluntary. The legal guardians of the child (usually the parents) must also give their free consent.

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[47] dutchnews.nl/news/archives/2017/04/number-of-official-cases-of-euthanasia-rise-10-in-the-netherlands/

[48] Recall that VE refers to "voluntary euthanasia" and PAS refers to "physician assisted suicide"

[49] John Keown DCL, ""Voluntary Assisted Dying" in Australia: The Victorian Parliamentary Committee's Tenuous Case for Legalization", *Issues in Law & Medicine*, Volume 33, Number 1, 2018, 70-71

The first minor reported to have been euthanased under these regulations occurred in September 2016. It is not known, of course, how many children have been killed outside of the law, remembering that where adults are concerned only 50% of euthanasia (voluntary) cases are reported while non-voluntary euthanasia cases are not reported at all.

Recall the criteria for the slippery slope argument articulated earlier:

1. that despite the presence of legal safeguards, the practice of euthanasia always involves alongside of it the practice of non-voluntary euthanasia; and/or
2. that legalisation of voluntary euthanasia will lead to calls for euthanasia for increasing types of cases, and especially for those who are not terminally ill.

The evidence shows that both criteria in Belgium, as in the Netherlands, are well and truly met. That evidence demonstrates that euthanasia, both voluntary and non-voluntary, are uncontrolled in Belgium despite the "strict" requirements of the law, and that the grounds for legal killings increase over time as euthanasia becomes routinised as just another medical procedure.

The Netherlands: empirical evidence that once accepted in principle for hard case, the categories of eligible persons widen

Over the years the grounds for euthanasia in the Netherlands have greatly widened. Euthanasia in that country is no longer just about the request of competent terminally ill adults to be killed by a doctor subject to strict conditions. Euthanasia is now tolerated for non-dying patients with psychiatric disorders, those who are comatose or demented, and others who are just sick of life.

For example, the website of the Government of the Netherlands makes it clear that the killings of newborn babies with serious disorders is permitted subject to certain guidelines.

> **Euthanasia and newborn infants**
>
> **Children are occasionally born with such serious disorders that termination of life is regarded as the best option.**
>
> **The law permits physicians to terminate the lives of newborn infants and to perform late-term abortion only on condition that they fulfil the following due care criteria:**
>
> **In the light of prevailing medical opinion, the child's suffering must be unbearable and with no prospect of improvement. This means that the decision to discontinue treatment is justified. There must be no doubt about the diagnosis and prognosis;**
>
> **Both the physician and the parents must be convinced that there is no reasonable alternative solution given the child's situation;**
>
> **The parents must have given their consent for the termination of life;**
>
> **The parents must have been fully informed of the diagnosis and prognosis;**
>
> **At least one other, independent physician must have examined the child and given a written opinion on compliance with the due care criteria listed above;**
>
> **The termination must be performed with all due care.**[50]

The Remmelink Commission (1991) had stated that the Dutch doctors regard the "intolerable suffering of the patient and/or his natural desire for a 'quiet death' as the only grounds on which to perform

[50] From the website of the Government of the Netherlands www.government.nl/topics/euthanasia/contents/euthanasia-and-newborn-infants

euthanasia."[51] John Keown has observed that "the reference to these grounds in the alternative, without disapproval, is revealing: it confirms that neither all doctors nor the Commission regard both as essential for euthanasia to be permissible."[52] But the "desire for a quiet death" is not one of the grounds for legally tolerated euthanasia. And, as far as the actual practice of euthanasia is concerned, the Dutch Survey Report's recorded reasons for requesting euthanasia casts considerable doubt on whether euthanasia was confined to patients who were "suffering unbearably" and for whom this was a "last resort". In most cases, 57%, the reason given was a "loss of dignity" (ontluistering), while 46% said "not dying in a dignified way" (onwaardig sterven), 33% said "dependence" (afhankelijkheid), and 23% "tiredness of life" (levensmoeheid). Only 46% mentioned "pain" (pijn).[53] Subsequent events have shown that non-life-threatening conditions now fall within the meaning of intolerable pain such that a person may have access to euthanasia for psychiatric reasons even though the existence of a serious psychiatric condition raises fundamental questions about the competence of the patient to make such a request.

There is in fact a slippery slope from voluntary euthanasia for those suffering intolerably with a terminal condition to those not suffering intolerably with a terminal condition, to those with non-terminal conditions such as psychiatric illness, and to children "born with such serious disorders that termination of life is regarded as the best option". And the terms in which children can be killed are vague and subjective.

Measures introduced to provide relief to late-stage cancer patients in places like the Netherlands has now been expanded to include people who might otherwise live for many years. Persons with diseases such as muscular dystrophy, dementia and other forms of mental illness including mentally ill young people, and those who are simply "sick of life" are now included within an ever-widening set of groups of people who are killed by their doctors under the rubric of euthanasia. The logic is clear enough.

> **If we are willing to make an exception to the rule that direct killing of an innocent human being is always wrong, then it only becomes a matter of "haggling over the price." If killing by euthanasia can be allowed for a deeply emotional reason, it can certainly be allowed for other reasons too, and soon for nearly any reason, making it difficult, if not impossible, to put the cat back into the proverbial "moral bag."**[54]

The evidence from The Netherlands shows that the strict medical guidelines as laid down by the courts and later by legislation are neither followed nor enforced. The evidence also shows that the practice of voluntary euthanasia is accompanied by a bigger practice of non-voluntary euthanasia. And it has always been that way.

Victoria begins its slide

The Premier of Victoria made this statement about Victoria's new euthanasia Act: "[We] anticipate in the first twelve months based on overseas experience, around a dozen people will access voluntary

[51] *Medische Beslissingen Rond Het Levenseinde* - Het onderzoek voor de Commissie Onderzoek Medische Praktijk inzake Euthanasie, The Hague, The Netherlands: Sdu Uitgeverij, 1991, [*Dutch Euthanasia Survey Report*], 32

[52] John Keown ed., *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, Cambridge, Cambridge University Press, 1995, 293, footnote 126

[53] These figures may be found in *Medische Beslissingen Rond Het Levenseinde* - Het onderzoek voor de Commissie Onderzoek Medische Praktijk inzake Euthanasie, The Hague, The Netherlands: Sdu Uitgeverij, 1991, [*Dutch Euthanasia Survey Report*], Tabel 5.8, page 35

[54] Tadeusz Pacholczyk, "'Exceptions' and the undermining of the Moral Law", *Making Sense of Bioethics*, February 2019. Microbiologist and bioethicist Dr Pacholczyk is the Director of Education at The National Catholic Bioethics Center in Philadelphia, US

assisted dying. And we would think that number would settle at around 100, 150 per year in the years after. As I said, this is a conservative model."[55]

The third report into the operation of the assisted dying legislation in Victoria was issued in August 2020. That report makes it clear that in the first 18 months of operation 124 people died either by self-administration of a lethal cocktail of drugs (104) or at the hands of a medical practitioner administering the drug to the patient (20).[56]

Table 1: Requests received from 1 January 2020 to 30 June 2020 and since 19 June 2019

STAGE		STATUS	SUBTOTAL (19 June–31 December 2019)	SUBTOTAL (1 January–30 June 2020)	TOTAL^ (19 June 2019–30 June 2020)
Eligibility	First assessment	Eligible	136	205	**341**
		Ineligible	1	6	**7**
	Consulting assessment	Eligible	109	188	**297**
		Ineligible	3	1	**4**
Permit applications	Self-administration permit	Issued	75	126	**201**
		Not issued*	16	16	**32**
	Practitioner administration permit	Issued	11	19	**30**
		Not issued*	4	5	**9**
	Withdrawn	Case withdrawn from portal by medical practitioner or upon notification of death of applicant**	35	99	**134**
Medications dispensed	For self-administration#		57	97	**154**
Confirmed deaths##	Medication was administered	Medication was self-administered	37	67	**104**
		Medication was administered by a practitioner	9	11	**20**

So much for the Premier's point of departure (12 deaths in the first 12 months). The years ahead do not look promising.

Add to the statistical facts made available in this report, the Voluntary Assisted Dying Review Board also quietly recommended changes to the Act to provide for active promotion of euthanasia to the community. This could be achieved by

> **promoting greater community awareness and conversations about end of life, including voluntary assisted dying.**[57]

as well as by changing the Act to provide for the legal right

> **for medical practitioners to initiate a conversation about voluntary assisted dying (currently constrained by legislation).**[58]

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[55] "The Victorian Government expects about a dozen people to use the laws in the first year", https://www.abc.net.au/news/2019-06-16/the-victorian-government-expects-about-a-dozen/11214608?nw=0, 16 June 2019

[56] Voluntary Assisted Dying Review Board, *Report of operations,* Victoria State Government, August 2020, 3

[57] *Ibid.*, 16

[58] *Ibid.*

Euthanasia is to be promoted and doctors authorised to raise the option with the patient if this Board gets its way, which it may well do. The attempts to widen the scope of the law in the State of Victoria have already begun just as they have in other euthanasia practising jurisdictions around the world.

Australia

South Australia

Euthanasia has been practiced in many forms in Australia. The empirical evidence here is that the practice of VAD and euthanasia generally, although carried out illegally, is accompanied by a significant practice of non-voluntary killings by doctors. Two examples of the evidence should suffice.

In South Australia the Parliament commissioned some research into the practice of euthanasia even though it was, at the time, not legally tolerated. It was conducted by scholars from Flinders University.

In their report of a sociological survey of the attitudes and practices of medical practitioners and nurses in South Australia,[59] Christine Stevens and Riaz Hassan found that 19% of medical practitioners and nurses had at some time taken active steps to bring about the death of a patient.[60] Their most striking discovery, however, was that 49% of those who had done so had never received a request from a patient to take such active steps.[61] That is, in a jurisdiction in which euthanasia in any form was legally prohibited, 19% of the medical profession agreed that they had been involved in euthanasia, but half of those 19% had done so without reference to the patient.

Australian surgeons

In 2001, a survey of attitudes and practices of surgeons in Australia in relation to hastening death, found that doctors will kill patients without their knowledge and consent. In this survey, responded to by 68.9% of eligible general surgeons, the following conclusions were reached:

> **Two hundred and forty-seven respondents (36.2%) reported that they had, for the purpose of relieving a patient's suffering, given drugs in doses greater than those required to relieve symptoms with the intention of hastening death (Question 1, Box 2 (#box2)). Of these, 139 indicated (in response to questions 3, 5 and 6, Box 2 (#box2)) that they had never received a sincere and unambiguous request for a lethal injection, and had never granted a request for assisted suicide. Thus, at least 20.4% of the entire sample (139/683; 95% CI, 17.4%–23.6%) have apparently given drugs with the intention of hastening death, but without the explicit request of the patient. Of the remaining 108 respondents who reported having given drugs with the intention of hastening death, it is unknown whether they have ever done so in the absence of a request.**[62]

In summary, it seems that one third of Australian general surgeons had killed patients. Of those surgeons who had killed patients, 56% said, "that they had never received a sincere and unambiguous request for a lethal injection". Of the rest, it is unknown whether they had ever killed a patient without request.

The illegal practice of euthanasia in Australia indicates that more are killed without their knowledge and consent than with their knowledge and consent.

It is difficult to imagine why those doctors who violate the law against intentional killing would be more law-abiding if the law should become much more relaxed, even permissive, of euthanasia.

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[59] Christine A Stevens and Riaz Hassan, "Management of death, dying and euthanasia: attitudes and practices of medical practitioners in South Australia", Journal of Medical Ethics, March 1994, volume 20 no 1, 41–46
[60] Christine A Stevens and Riaz Hassan, *ibid.*, 43
[61] Christine A Stevens and Riaz Hassan, *ibid.*, 43
[62] Charles D Douglas, Ian H Kerridge, Katherine J Rainbird, John R McPhee, Lynne Hancock and Allan D Spigelman, "The intention to hasten death: a survey of attitudes and practices of surgeons in Australia, *The Medical Journal of Australia* 2001; 175: 513

The World

For a comprehensive review of all places in the world with legalised euthanasia and physician assisted suicide, I recommend Richard Egan, *Fatally Flawed Experiments in Assisted Suicide and Euthanasia*, 2021, and freely available online.[63]

Transference and Andrew Denton

> **Transference is a psychology term used to describe a phenomenon in which an individual redirects their emotions and feelings, often unconsciously, from one person to another.**[64]

In the context of human suffering and euthanasia and assisted suicide, a relative takes on the suffering of the patient. Simply seeing a very sick relative or loved one, makes the healthy person feel their pain. In asking the doctor to end their loved one's suffering by ending that person's life, we may see an instance of the healthy asking the doctor to "please put grandma out of **my** misery". Transference is usually unconscious and not an example of malice.

An example of this may be seen when Australian entertainer and euthanasia activist, Andrew Denton, used his father's dying and death as a clear case of why euthanasia should be applied but seems unable to realise his use of transference.

Denton has published a series of podcasts titled "Better off Dead".[65] In his 13th podcast he says this:

> **Dad did not go gentle. Although clearly dying of heart failure, and obviously in great pain, he was assisted to die in the only way that Australia's law then – and now – would allow: He was given increasing doses of morphine to settle the pain.**
>
> **But morphine never did settle the pain, not his and not ours.**[66]

What happened here? What are the medical facts of the matter? Here we are assisted by the insights of the Dentons' "old family doctor", Vic Dawson. Dr Dawson, at Denton's invitation, makes these comments on Kit Denton's medical treatment:

> **I think even at that stage they were still trying to treat his heart failure and still trying to treat his liver and kidneys medically, and they were using almost that double-principle of, if they gave him too much they would kill him, so they couldn't give him enough to give him pain relief. And I've never seen the logic in that.**
>
> **There should've been no reason not to give him quite strong pain relief that would have made him deeply unconscious and non-responsive to pain. I don't think there's any excuse for that treatment.**[67]

From Dr Dawson's point of view, Kit dying in pain should never have occurred, that there should have been an intensification of pain relief even if that should make Kit unconscious or even shorten life. Dr Dawson believed that palliative sedation could and should have been applied.

Completely ignoring what Dr Dawson said, even though he asked Dr Dawson for his opinion, Denton responds in this way:

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[63] https://d3n8a8pro7vhmx.cloudfront.net/australiancarealliance/pages/94/attachments/original/1630382355/Fatally_Flawed_Experiments.pdf?1630382355

[64] https://www.goodtherapy.org/blog/psychpedia/transference

[65] https://podcasts.apple.com/au/podcast/better-off-dead/id1056470744

[66] Podcast 1

[67] Dr Vic Dawson, Denton family doctor, Podcast 1

> **Listening to Vic, I couldn't help but wonder to whose benefit was dad kept alive for three more days of pain? Wouldn't it have been better, instead, to help him to die quickly and peacefully?**

Later, Denton was to attack internationally renowned Catholic bioethicist, Anthony Fisher (who is also the Catholic Archbishop of Sydney) on the subject of "transference". He accused Fisher of sowing the seeds of what he calls "FUD". In Denton language, FUD stands for "Fear. Uncertainty. Doubt".[68] Denton, blind to his own confession of transference ("But morphine never did settle the pain, **not his and not ours**."), seeks to show that we need not be concerned with transference as an influencing factor in decisions made where euthanasia is concerned.

But there is an abundance of evidence to show the reality of transference as a psychological experience, particularly for women.[69]

Transference can be good if it leads us to a right sense of compassion (meaning "to suffer with") which leads to good actions on our part to assist the person in distress. But it can be a bad thing when we imagine that compassion, by itself, necessarily suggests the right thing that ought to be done. As remarked earlier, **compassion is the motive which impels us to act once we know what is the right thing to do**.

The eugenic impulse to rid the world of unwanted burdens

At the heart of the public policy debate on medical killings and assisted suicide is eugenics, the idea that there are certain lives not worthy to be lived. It may be a personal judgement that one can make that I am sick of my life because it has become so greatly attenuated with the consequences of illness and disability. It often is, however, a judgement made by other who think that certain human beings are better off dead.

The incremental extension of the practice of euthanasia involves the move from euthanasia for a few very hard cases to more and more types of cases involving adults who lack mental capacity and cannot competently ask for it (the demented) and to children who, by their age alone, lack the capacity to give consent. In the great debates on euthanasia in the British Parliament in 1936 and 1950, the real intentions of euthanasia advocates were made abundantly clear. They were more interested in non-voluntary euthanasia. For example, Lord Chorley,[70] who introduced "a motion calling attention to the need for legislation on voluntary euthanasia to the House of Lords", had this to say:

> **One objection to the Bill, he said, is that it "does not go far enough, because it applies only to adults and does not apply to children who come into the world deaf, dumb and crippled, and who have a much better cause than those for whom the Bill provides. That may be so, but we must go step by step".**[71]

For a full discussion on the ubiquity of the eugenics mentality in this country and elsewhere, see my To Kill or Not to Kill.[72]

Euphemisms and Legislation

Legislation, and the arguments for it, should be transparent. The words should mean exactly what they say. Euthanasia involves the intentional killing of a patient by direct act or by neglect of reasonable care and motivated by the parlous position in which the patient finds himself or herself.

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[68] Podcast 13

[69] Mariët Hagedoorn, Bram P Buunka, Roeline G Kuijerb, Theo Wobbes and Robbert Sanderman, "Couples Dealing With Cancer: Role and Gender Differences Regarding Psychological Distress and Quality of Life", *Psycho-Oncology* 9: 232–242 (2000); C Pitceathly and P Maguire, "The psychological impact of cancer on patients' partners and other key relatives: a review", *European Journal of Cancer*, Volume 39, Issue 11, July 2003, Pages 1517–1524

[70] NDA Kemp, *Merciful Release: The History of the British Euthanasia Movement*, Manchester University Press, 2002, 140

[71] Quoted in Yale Kamisar, "Euthanasia legislation: some non-religious objections", in A. B. Downing and Barbara Smoker, *Voluntary Euthanasia*, Peter Owen, London, 1986, p. 131.

[72] John Fleming, *To Kill or Not to Kill*, London, Austin Macauley Publishers, 2021, pages 403-458

Where voluntary euthanasia is concerned, the killing of the patient should be at the competent and current request of the patient as an act of self-determination.

Physician assisted suicide is suicide either by patients taking a lethal dose or having a lethal dose applied to them. The object of such legislation is to make an exception to the law on homicide.

However, arguments used by proponents of such legislation are often couched in euphemisms meant to hide the real nature of what is proposed. It is to the credit of the philosophers Peter Singer and Helga Kuhse (and there are others) that they are clear in their language, that euthanasia is about killing.

Examples of euphemisms include "helping a person to die", "gentle death", "putting to sleep" and "assistance in dying". Using these terms, pro-euthanasia activist Andrew Denton, then goes on to make this plainly ludicrous claim:

> **Denton: Okay, secondly, let me talk about the use of the word kill. The vast majority of the people who these laws apply to are already dying. That's what it's about.**
>
> **The overwhelming majority of these people who these laws have applied to overseas are dying and have died of cancer. It is their disease that's killing them.**
>
> **What this law is for, a very strictly written law following very clear criteria to protect doctors from prosecution, should they follow the criteria, what this law is for is to assist them to die in a merciful way, not to kill them, they are going to die anyway.**[73]

Using euphemisms this kind of argument is a denial of reality leading to the claim that when you kill someone who is dying you didn't kill them, it was the disease that killed them. Also note the suggestion that the law should be about protecting doctors while making no reference to the protection of vulnerable patients.

Moreover, if it were not about killing, if it is not about assisting in suicide, why would we need legislation giving legal permission for these killings?

Opinion Polls

Where decisions are being made about radical change to public policy, appeal is often made to public opinion. Politicians are elected to make difficult decisions on a raft of matters and have the time to get themselves informed in the way that nearly all citizens do not. The translation of single-question opinion polls into legislation is problematic. Fair criticism of opinion polls points to the following problems:

1. opinion polls often record reflexive preferences rather than well thought out evidence-based opinions;
2. opinion polls tell us nothing about how well-informed subjects are on the issues upon which they are giving an opinion;
3. opinion polls may guide subjects to an answer by the way a question is expressed, and
4. opinion poll answers may be unduly influenced by hard cases.

Take for example capital punishment. Approval for capital punishment varies greatly depending upon what is put to people, and how afraid you can make people feel when confronted with a particularly extreme situation. For example:

> **A special snap SMS Morgan Poll today [2014] shows a small majority of Australians (52.5%) favour the death penalty for deadly terrorist acts in Australia**

[73] "Andrew Denton, Assisted Dying Advocate", *Lateline Interview*, Australian Broadcasting Corporation, Broadcast: 10/08/2016. Reporter: Emma Alberici, http://www.abc.net.au/lateline/content/2016/s4515903.htm

> **while 47.5% don't. This is a significant increase from 2009 when only 23% of Australians supported the death penalty being imposed for convicted murderers. Today's special SMS Morgan Poll was conducted with a cross-section of 1,307 Australians who were asked "*If a person is convicted of a terrorist act in Australia which kills someone, should the penalty be death?*"**[74]

The same applies to euthanasia. Ask a question which strikes fear into people's hearts, and you will, no doubt, get the answer you want.

> **Thinking now about voluntary euthanasia, if a hopelessly ill patient, experiencing un-relievable suffering, with absolutely no chance of recovering asks for a lethal dose, should a doctor be allowed to provide a lethal dose? [Newspoll]**[75]

The patient must have all the following issues present at one and the same time. The patient is:

a) "hopelessly ill", and
b) is experiencing suffering that cannot be relieved, and
c) has no chance of surviving the illness, and
d) asks for a lethal dose.

No wonder 82.5% of responders answered "yes". Note also that respondents were not asked about the efficacy of safeguards as far as the community is concerned.

Conclusion

In this submission I argue that the elected representatives of the parliament be guided the following considerations:

1. The primary duty of members of parliament is to protect equally and impartially the lives of all citizens.
2. A legal right for the individual to either kill themselves or have someone else kill them places the lives of others at serious risk of being killed without their knowledge and consent. This should weigh heavily on the minds of parliamentarians if they are to take seriously their first and **overriding duty to protect the lives and security of all citizens equally and impartially**. The lives of the weakest and most vulnerable are of no less valuable than those who want someone to kill them or to assist them in killing themselves.
3. To be realistic about human nature and the fallibility of legal safeguards when creating an exception to the general rule against homicide, ie the killings of innocent human beings even at their own request.
4. The various acts of assisting a suicide or directly killing a patient necessarily occurs in private when there is no objective oversight into what is happening. Many doctors seem not to think that the law has any part to play in the way they practice medicine. If, for example, a sizeable percentage of doctors kill their patients when it is illegal to do so, why would one imagine that they would be anymore law-abiding after legalization subject to safeguards.
5. The hard evidence that is freely available about what happens when one creates exceptions to the rule against homicide even when surrounded by safeguards.
6. The abundant use of euphemisms in the debate betrays the reality that legalised euthanasia and physician assisted suicide is not being confronted for what it actually is, one person killing another or assisting another to kill themselves.
7. Hard cases are not a justification for bad laws.

[74] Roy Morgan Research, "Small majority of Australians favour the death penalty for deadly terrorist acts in Australia", http://www.roymorgan.com/findings/5814-death-penalty-for-terrorist-acts-september-19-2014-201409190533

[75] https://dwdq.org.au/wp-content/uploads/2017/08/Polls-on-VE-from-2007-to-2016-Updated.pdf

8. The fact of some hard cases drives us to the most effective means of palliative care and to make that care actually available in rural and remote areas as it is in cities.
9. That the duty to protect the weakest and most vulnerable persons in society must be the over-riding public policy consideration.
10. That members of parliament, while acknowledging personal moral opinions in favour of euthanasia accept the advice that nevertheless the passing of this voluntary assistance in dying legislation is unwise and dangerous public policy.
11. That the debate be no longer characterised by appeals to hard cases, emotion, and personal subjective opinions, but by the serious public policy consideration outlined in this submission.

An afterthought

Because the other States in Australia have gone down the path of legalised euthanasia and assisted suicide there is no reason for NSW to follow suit. It would be, to say the least, prudent to watch and see what happens in those other States as a result of their legislation. On the face of it, it is not likely that the end result will be dissimilar to what has happened to jurisdictions in other continents. If that turns out to be the case, NSW will present itself as an example to the nation as to how best to treat dying patients, patients with serious mental illnesses, the demented elderly, and seriously ill children.

Once, however, the protection of the lives of citizens is compromised, there will not be any easy way to repair the damage, to restore faith and trust in governments to be faithful to the social contract, or even to restore complete trust in doctors and other health care professionals.

Dr John I Fleming

25 November 2021