

To: the Members of the Parliament of South Australia
From: Professor John Keown, Kennedy Institute of Ethics, Georgetown University

5th April 2011

Dear Members of the Parliament of South Australia,

Criminal Law Consolidation (Medical Defences-End of Life Arrangements) Amendment Bill 2011

Proposals to permit voluntary euthanasia (VE) physician-assisted suicide (PAS) have, with very few exceptions, been repeatedly rejected by state and national legislatures, medical professional associations and by expert committees around the world. It is not difficult to see why.

First, such proposals offend the fundamental moral and legal principle of the inviolability of life which affirms the equality-in-dignity of all patients, regardless of illness or disability. The law's prohibition of intentional killing was described by the House of Lords Select Committee on Medical Ethics in its landmark report of 1994, which rejected the arguments for VE and PAS, as 'the cornerstone of law and of social relationships' which 'protects each one of us impartially, embodying the belief that all are equal'.

Secondly, such proposals especially endanger vulnerable groups including the elderly, the dying, the depressed and the disabled. If the law were to embrace the entirely arbitrary notion that some patients' lives are no longer 'worth living', that some patients are 'better off dead', the vulnerability of those groups would only be heightened. It is no surprise that disability rights groups are among the leading opponents of VE and PAS.

Thirdly, decriminalising VE is merely a first step to the decriminalisation of euthanasia without request. This is not simply because this is the intention (overt or covert) of many advocates of VE and because of the intractable difficulties of framing and enforcing 'safeguards'. It is also because of the internal logic of the case for VE.

For: if it is right to administer a lethal injection to a patient who requests it because death is thought to benefit the patient (and no responsible doctor would end the patient's life unless the doctor thought that death would benefit the patient) why is it not right to administer a lethal injection to an incompetent patient for whom death is equally thought to be a benefit? The Bill before you greases the logical slope *by explicitly endorsing the judgment that it is reasonable to end the lives of certain patients*. A central ingredient of the defence in the Bill is that the doctor (not, we may note, the patient) believed that life had become 'intolerable', and the Bill states in terms that 'Parliament intends that conduct bringing about the end of a person's life is a reasonable response' to certain patients. But if death would benefit those patients, why should they be denied this benefit merely because they cannot request it?

This logical 'slippery slope' argument is unanswerable. Its force has dawned even on the Dutch. In the 1980s the Dutch courts decriminalised VE; in the 1990s they endorsed euthanasia without request. In the 1980s Dutch euthanasia advocates were telling patients that they would have to 'fight' to get euthanasia. By 2003 (having discovered that Dutch doctors were killing many incompetent patients) they had changed their tune:

it is the patient who is now responsible in the Netherlands for avoiding termination of his life; if he does not wish to be killed by his doctor then he must state it clearly orally and in writing, well in advance.¹

Dutch claims of having prevented the 'slippery slope' through 'safeguards' ring hollow. As do claims that there is no abuse in Oregon, where the 'safeguards' for PAS are in major respects even more attenuated. The

¹ Quoted in John Keown, *Considering Physician-Assisted Suicide* (2006, www.carenokilling.org) p6.

'safeguards' in the euphemistically titled 'End of Life Arrangements' Bill are, remarkably, weaker still. This poorly and loosely-drafted measure prompts many concerns, not least the following:

1 What is to prevent a patient from 'shopping around' to find any compliant doctor, however many doctors (including the patient's regular doctor) may have declined to comply with the patient's request? And if a 'treating doctor' is not the patient's regular doctor, why is a 'treating doctor' not required to consult the patient's regular doctor, or indeed any doctor? Need the patient's relationship with a 'treating doctor' have lasted more than 5 minutes?

2 What is meant by an 'express request'? Need it be voluntary? Need it be informed and, if so, how? Presumably, a single request would suffice. And could it be contained in an advance directive even though the patient is no longer competent?

3 What is meant by an 'implied' request? Would it include: 'I can't wait to meet my loved ones on the other side'?

4 What is meant by 'sound mind', and would a defendant have 'reasonable grounds' for believing that the patient was of 'sound mind' if the patient seemed to be so on the basis of a 5 minute meeting?

5 Given that, as the Royal College of Psychiatrists cautioned in its important statement opposing PAS in 2006, there is a clear association between suicidal desire and clinical depression, that 98% of depressed patients who are treated change their minds about wanting to die, and that many doctors are not trained to recognise depression, why does the Bill not require careful evaluation of the patient by a psychiatrist? And even if the patient were of 'sound mind' when the request (express or implied) were made, how can the Bill ensure that if the patient later takes a lethal substance, perhaps months or years later, the patient is then of sound mind, or is not acting under undue influence?

6 Why does the Bill not require evaluation of the patient by an expert in the patient's 'illness, injury or other medical condition'?

7 Why does the Bill not require evaluation of the patient by an expert in palliative care?

8 Does an 'illness, injury or other medical condition that irreversibly impaired the person's quality of life so that life had become intolerable to that person' include infertility; diabetes; obesity; arthritis; deterioration of hearing; depression in a teenager as a result of abuse suffered as a child; or depression in an adult as a result of long-term unemployment?

9 When would ending the patient's life not be a 'reasonable response' given that 'Parliament intends that' it can be in 'exceptional circumstances'. What circumstances are 'exceptional'?

10. Why does the Bill not contain even the minimal independent consultation and review requirements found in the Netherlands?

It appears that some of the Bill's defenders have claimed that the Bill would not permit euthanasia and would be limited to the terminally ill who are in pain. Such claims are inconsistent with the Bill's own terms.

In short, the Bill is defective in principle and would prove unenforceable and dangerous in practice. If it were enacted, it would leave South Australia with one of the laxest laws for ending patients' lives in the world and provide an open invitation to any doctor who wished to set up a euthanasia business.

I hope you find these comments of some assistance in your consideration of the Bill.