The legislation of active voluntary euthanasia in Australia: will the slippery slope prove fatal?

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Abstract

At 2.00 am on the morning of May 24, 1995 the Northern Territory Legislative Assembly Australia passed the Rights of the Terminally Ill Act by the narrow margin of 15 votes to 10. The act permits a terminally ill patient of sound mind and over the age of 18 years, and who is either in pain or suffering, or distress, to request a medical practitioner to assist the patient to terminate his or her life. Thus, Australia can lay claim to being the first country in the world to legalise voluntary active euthanasia. The Northern Territory's act has prompted Australia-wide community reaction, particularly in South Australia, Tasmania and the Australian Capital Territory where proposals to legalise euthanasia have already been defeated on the floor of parliament. In New South Wales (NSW) the AIDS Council of NSW has prepared draft euthanasia legislation to be introduced into the Upper House as a Private Member's Bill some time in 1996. In this paper, we focus on a brief description of events as they occurred and on the arguments for and against the legalisation of euthanasia which have appeared in the media.

In the early hours of the morning of 24th May 1995 the Northern Territory Parliament passed the Rights of the Terminally Ill Act 1995, making Australia the first country in the world to have legalised voluntary euthanasia. The final amendments to the act, regarding the role of psychiatrists and interpreters, were passed on the 20th February, 1996. Meaning that within months active voluntary euthanasia became a clinical and legal choice for terminally ill patients. No government has gone as far as the Northern Territory's Legislative Assembly in legalising voluntary euthanasia for the terminally ill.

Background: the Netherlands

In the Netherlands, active voluntary euthanasia remains a criminal offence under article 293 of the

penal code of the Netherlands.¹ Any person who terminates the life of another person at the latter's express and earnest request is liable to a term of imprisonment not exceeding 12 years. In the absence of a patient request the perpetrator renders himself guilty of manslaughter or murder.² Moreover, the present government has *not* adopted a longstanding proposal to legalise euthanasia. Instead, it has decided that physicians who terminate life on request of the patient will not be punished only if they invoke a defence of *force majeure* and have satisfied the criteria discussed below, and then only on condition that the court accepts this defence.³ Such possible immunity from prosecution applies only to doctors. Thus, doctors practising euthanasia do so in violation of the law. In practice, however, they will not be prosecuted if they appear to have followed strict guidelines. Three tiers of the Dutch judicial system – district courts, appeal courts, and the supreme court – have handed down judgments in which these guidelines are precisely defined. They have been affirmed and elaborated upon by the Royal Dutch Medical Association (KNMG), the State Commission on Euthanasia, and the Dutch government.⁴

In brief, these conditions require, amongst other things, that there be an explicit and repeated request by the patient that leaves no reason for doubt concerning his desire to die; that the mental or physical suffering of the patient must be very severe with no prospect of relief; that the patient's decision be well-informed, free, and stable over time; that all options for other care have been exhausted or refused by the patient; and that the doctor consult another physician (in addition, he may decide to consult nurses, pastors, and others). The doctor is advised to record the course of events. Although data from studies differ it is estimated that active voluntary euthanasia occurs in approximately 1.8% of deaths in the Netherlands and nearly always in terminally ill patients with a prognosis of less than one month.⁵

Key words

Active voluntary euthanasia in Australia; legislation in Australia; arguments for euthanasia; arguments against euthanasia; the slippery slope.

The issue

The issue of whether patients should be able to request euthanasia raises a number of complex moral, legal and social issues. Advances in medical

technology, progress in palliative and hospice care, changing attitudes to death, a shift in demographics towards an older population, the emergence of the civil rights movement and a changing perception of medical decision-making have brought euthanasia into prominence in Australia. Before these changes can be considered we need to recognise a series of basic distinctions, as the term “euthanasia”, which literally means a “good, gentle or easy death” may be used in many different ways, creating considerable confusion. *Active voluntary euthanasia*, or the killing of a patient at his request, must be distinguished from the decision to terminate the lives of patients who do not have the capacity to comprehend and so cannot provide meaningful consent, (*non-voluntary euthanasia*) and the decision to terminate the lives of patients either against their will or without their knowledge (*involuntary euthanasia*). Nearly all health care professionals, ethicists and politicians repudiate involuntary and to a somewhat lesser extent, non-voluntary euthanasia. The situation with active non-voluntary euthanasia is unclear because decisions prematurely to end the life of, for example, a severely disabled neonate, or a person in a permanent vegetative state, remain ethically contentious where the prognosis is uncertain.¹ The current debate, which gave birth to the Northern Territory legislation concerns “active voluntary euthanasia”.

Current status in Australia

On May 24th, 1995 the Legislative Assembly of the Northern Territory approved legislation making active voluntary euthanasia legal. The Northern Territory is home to only 175,000 people, half of whom live in Darwin, the state capital, where the single chamber state parliament and its 25 members are located. The passage of the Northern Territory legislation was remarkable, not just for its success but for the circumstances surrounding its legislation. The proposed legislation was first given impetus by the Chief Minister, Marshall Perron, when introduced as a private member’s bill. The bill was eventually passed by one of the world’s smallest legislative assemblies by 15 votes to 10 in a highly emotional mood after a limited debate, characterised by a disconcerting sense of urgency and a lack of consultation. The act now permits a terminally ill patient of sound mind, over the age of 18 years, and who is either suffering, or in pain or distress, to request a medical practitioner to assist him to terminate his life.⁶ Doctors are free to choose whether they will assist the patient in dying and the act itself states that it is a criminal offence to coerce or threaten a doctor for refusing to help a patient die. Further details and the conditions under which a medical practitioner may assist are set out in table 1. Provided medical practitioners comply with the provisions of the act, they will be immune to both criminal and civil legal actions.

Since the Rights of the Terminally Ill Act was passed into law it has been condemned by the Central Land Council, representing the Northern Territory’s Aboriginal population (approximately 40,000), which criticised the law as being both “culturally inappropriate” and a significant disincentive for elderly Aborigines to seek medical care. A legal challenge is currently being prepared.⁷ In the short period of time since its passage the Northern Territory act has prompted Australia-wide debate on the question of the legalisation of euthanasia. In New South Wales, the AIDS Council of NSW has announced its intention to table a private bill in the state parliament, regarding the legalisation of voluntary euthanasia, some time during 1996. Bills

Table

Patient and doctors

1. the patient is at least 18 years and the medical practitioner is satisfied reasonably that:
(i) the patient is suffering from an illness that will, in the normal course of events result in the death of the patient; (ii) there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure; and, (iii) any medical treatment reasonably available to the patient is confined to the relief of pain and/or suffering with the object of allowing the patient to die a comfortable death;
2. a second medical practitioner, has examined the patient and has confirmed: (i) the first medical practitioner’s opinion as to the existence and seriousness of the illness; (ii) that the patient is likely to die as a result of the illness; (iii) the first medical practitioner’s prognosis; and, (iv) that the patient is not suffering from a treatable clinical depression in respect of the illness;
3. the illness is causing the patient severe pain or suffering;

Process to be followed and documentation:

4. the medical practitioner has informed the patient of the nature of the illness and its likely course, and the medical treatment, including palliative care counselling and psychiatric support and extraordinary measures for keeping the patient alive, that might be available to the patient;
5. after being informed as in 4, the patient indicates to the medical practitioner that the patient has decided to end his or her life;
6. the medical practitioner is satisfied that the patient has considered the possible implications of the patient’s decision to end his or her life has been made freely, voluntarily and after due consideration;
7. the patient, or a person acting on the patient’s behalf has, not earlier than 7 days after the patient has indicated to his or her medical practitioner in 5, signed that part of the certificate of request required to be completed by or on behalf of the patient;
8. the medical practitioner has witnessed the patient’s signature on the certificate of request and has completed and signed the relevant declaration on the certificate;
9. the certificate of request has been signed in the presence of the patient and the first medical practitioner by another medical practitioner after that medical practitioner has discussed the case with the first medical practitioner and the patient and is satisfied, that the certificate is in order, that the patient is of sound mind and the patient’s decision to end his or her life has been made freely;
10. the medical practitioner has no reason to believe that he or she will gain a financial advantage directly or indirectly as a result of the death of the patient;
11. no less than 48 hours has elapsed since the signing of the completed certificate of request;
12. at no time before assisting the patient to end his or her life had the patient given to the medical practitioner an indication that it was no longer the patient’s wish to end his or her life;
13. the medical practitioner himself or herself provides the assistance and/or is and remains present while the assistance is given and until the death of the patient.

incorporating conscience votes on the legalisation of euthanasia have already been presented and defeated in the Tasmanian, South Australian and, Australian Capital Territory parliaments despite consistent indications from public opinion polls that seem to favour the “right” of terminally ill patients to end their lives with medical assistance.^{8,9}

The passage of the Northern Territory act has polarised ethicists and health care workers, being supported by the Voluntary Euthanasia Society, the AIDS Council of NSW and the Doctor’s Reform Society, and rejected by the Australian Medical Association, Right to Life organisations, mainstream Christian and Non-Christian churches and the major aged and disability national associations. Unfortunately, there has been limited public discussion, other than the occasional media articles and interviews, and even these have often been relatively shallow and unsophisticated, with little discussion of the broader moral, social and legal issues that may flow from such legislation. Public debate has been dominated by sloganeering, the most prominent slogans being “Death with Dignity”, “Right to Life” and “Right to Die”. Supporters of euthanasia have been accused of being murderers who wish to play God, whilst those who oppose euthanasia have been painted as lacking in compassion or respect for the rights and dignity of individuals. Both accusations are clearly inappropriate and unhelpful.

The pro-euthanasia position in Australia

Support for voluntary euthanasia is based on the contention that individuals should be granted the right to die, *when and how* they wish (death with dignity), and that those who assist them should be free from moral, professional or legal sanctions. Proponents of active voluntary euthanasia legislation in Australia argue that since Australia is a democratic society of great cultural, religious and moral pluralism where individual rights are respected, then individuals should have moral authority over their own lives and should be allowed the means to end their lives. Furthermore, they argue that to suggest that people are incapable of making such judgments about their own lives is to deny the humanity and common sense that we all share.¹⁰

Surveys on the attitudes and practices of Australian doctors towards euthanasia suggest that an implicit form of voluntary euthanasia already takes place within Australian hospitals.^{8,9} Research also suggests that there is some support for euthanasia within Australia’s medical and nursing professions.^{10,11} Indeed, the debate over active voluntary euthanasia was given considerable impetus in Australia by an open letter to the Victorian state government by seven doctors who claimed to have contributed to the death of patients with HIV/AIDS in contravention of the law.

Related to the importance of respect for a person’s

autonomous choices, including the right to die, is the importance of respect for an individual’s dignity. Advances in medical technology have increased medicine’s capacity to prolong life to the point where it is unnecessarily burdensome and may diminish an individual’s quality of life and personal dignity. At these times, where a person who is terminally ill experiences severe pain or suffering, voluntary euthanasia may represent the most compassionate and dignified option.¹² No person should be forced to endure suffering and those who relieve an individual’s suffering by euthanasia out of respect for autonomy and compassion are, it may be argued, acting humanely, if not ethically. Given that we accept autonomous refusal of treatment and the use of palliative medications that may inevitably hasten a patient’s death, to refuse a request for euthanasia is, it is argued, moral cowardice.

For many, the commonly invoked difference between “killing” a patient and “allowing to die” is ambiguous in many cases, and if patients are currently allowed to refuse treatment, even if it means that they will die, then they should also be permitted the option of euthanasia. Finally, recent public surveys consistently demonstrate strong support for the “right to die” in circumstances involving intractable pain and terminal illness.^{8,13,14}

The anti-euthanasia position in Australia

Whilst opponents of active voluntary euthanasia may be sympathetic to the arguments raised by the proponents of euthanasia they ultimately reject the notion that killing someone is morally equivalent to allowing them to die and put forward a series of arguments against the legalisation of euthanasia. A popular but somewhat paternalistic argument is that the law is a blunt instrument and lacks the finesse, sensitivity and compassion to deal with the dying and that legislation should not intervene at the bedside.³ It is also argued that medical knowledge is limited and cannot always predict the nature of an individual’s life, dying and death. Doctors may make incorrect diagnoses or fail accurately to predict an individual’s prognosis and even the sickest patient may recover. What is of concern about euthanasia is that, unlike other mistakes, once it is performed it cannot be reversed. The discovery of a new therapy or diagnostic error is of no value to a patient who is already dead and this risk of error weighs heavily against advocating euthanasia.¹⁵

Opponents of euthanasia also argue that there is a moral difference between killing and letting die. The contention is that it is morally acceptable and not unlawful to allow a patient to die when the burdens of further treatment outweigh the benefits but, it is *not* morally acceptable actually to intervene and *intentionally* kill a patient. This is reflected in clinical practice where the majority of health care professionals support the withdrawal or withholding

of treatment to ease suffering and avoid prolonging the process of dying.¹⁶ The distinction between killing and letting die is not uncontroversial however, and has been labelled as logically, clinically and philosophically ambiguous. Indeed there would appear to be a grey area between providing (or withdrawing) treatment that a doctor knows may contribute to a patient's death and deliberately hastening the time of death. If there is a moral difference, and most doctors would appear to believe that there is, then it probably lies in the *intent* of the clinician involved. The argument is that if the intention is to kill then this is morally abhorrent, whereas, if the intention is to relieve suffering and allow a natural dying process to continue, then this is morally acceptable.

Opponents of euthanasia also warn that any move to liberalise the law relating to the care of dying patients would herald a major change in the *ethos* of medicine. The argument is that the complicity of doctors in the death of patients may undermine the trust and confidence that patients have in their doctors and also diminish the public's perception that the health professions are dedicated to the health and welfare of their patients. Indeed, it is certainly possible that making the "intent to kill" part of the medical ethos would ultimately impair the trust and mutual respect that form the basis of the health care professional-patient relationship.¹⁷ The many physicians who support this argument do not reject the centrality of patient rights and autonomy in decision-making, but argue instead that whereas patients have a *right* to decline treatment, even where such treatment may be life-saving, they do not have the right to demand treatment, such as euthanasia, which the health care professional, who is concerned with the health and welfare of *all* patients, cannot morally provide. At this point, however, we are unable to determine whether the legalisation of euthanasia would have such an impact. Certainly there is no evidence from the Netherlands to suggest that this may be the case. It is well worth noting that those who advocate voluntary euthanasia do not generally dismiss the importance of trust, confidence and respect in health care, but argue instead that the role of health care professionals and the proper function of health care institutions is defined not by doctors but by society.

Since the passage of the Northern Territory euthanasia act, Christian and Non-Christian churches have spoken with a moral unanimity not seen in their discussion and reaction to other contemporary issues, such as abortion or homosexuality. Pope John Paul II has strongly condemned both abortion and euthanasia in his latest encyclical, *Evangelium Vitae* (The Gospel of Life), referring to what he called the "Culture of Death" prevalent in Western society.¹⁸ The Uniting and Anglican churches, together with the various Islamic councils

and the Right to Life Association, have all urged opposition to any moves to introduce voluntary euthanasia legislation. Each body rejects the argument that euthanasia is the ultimate human right, arguing instead for a prohibition on killing based upon a continued recognition of the *sanctity of life*, except for the just defence of others and in certain cases, self-defence.

A further concern that is frequently expressed in relation to the legalisation of euthanasia, centres on the interpretation of requests by patients for euthanasia. Many of those who work in palliative care and the hospice movement argue that the decisions or choices made by dying patients must not be too readily accepted, but instead be sensitively explored with the individual. The *real* wishes and needs of the dying are often elusive or poorly expressed because of their condition, the effect of medications, their fears and beliefs, the information presented to them and the biases, needs and beliefs of those caring for them. It is not difficult to imagine that where people are sick, suffering and aware of the burden they place upon others, that they may well choose to have their life terminated.^{17 19} Given the decreasing importance of the extended family, the institutionalisation of the elderly and the growing social problems of isolation and loneliness, can we be so sure of the ability of health care workers to detect when the patients' request for euthanasia arises out of their loneliness, or a desire on their part to diminish the burden they feel they are on those around them? Those who oppose euthanasia worry that the availability of a *quick death* may introduce *subtle* coercion on those who are frightened, powerless, or feel that their invalid state is a burden to others and that for the good of their family and the community, they should choose death not life.²⁰ Many palliative care/hospice physicians also argue that the process of dying is neither a science nor a "problem" to be "solved" by the application of medical technology. Rather, they argue that dying is best addressed not by the legislation of euthanasia, but by improving palliative care outreach services and hospice care such that terminally ill patients may "die with dignity" in their own homes. It is certainly interesting that those who work most closely with the terminally ill patients in Australia fear that the legalisation of euthanasia will "medicalise" yet another aspect of human life and death and that the deep spirituality, morality and humanness of death and dying will fall prey to the technological imperative. For palliative care and hospice workers the task is to recognise that death is approaching and prepare for it, rather than make an active decision for death. They generally contend that sensitive communication, humane care, compassion and affirmation of the worth of each individual is indisputably more important in the care of the terminally ill than aiming to "cure" the problem of dying with medical technology.¹⁹

It is also argued that acceptance of active voluntary euthanasia, even where it is strictly controlled, will lead down a psychological and philosophical *slippery slope*²¹ at the base of which lie altered attitudes to death and dying and the inevitable sanction of non-voluntary and involuntary euthanasia. The fear is that acceptance of euthanasia will create a dangerous precedent, where step by step cogent reasons may be advanced to justify broadening the circumstances in which euthanasia may occur. Initially limited to the terminally ill, the sphere of euthanasia may eventually encompass the elderly, weak, demented, socially unproductive or disabled – those most in need of support and care. Critics point to the data emerging from the Netherlands, which appear to indicate that even where strict regulations exist both non-voluntary and involuntary euthanasia may occur.²² The evidence from the Netherlands has become a major focus of continuing debate regarding the clinical and moral “success” of the decriminalisation of euthanasia. Although there are major discrepancies in the data, it would appear that both non-voluntary and involuntary euthanasia have already occurred in Holland, as reported in the Rummelink Report of 1990.²³ For opponents of euthanasia, this is a clear demonstration that any attempt to legislate for active voluntary euthanasia will lead to the killing of those *who do not wish to die*. For advocates of euthanasia, these figures represent what they believe is already occurring in Australia and merely the failure of the Dutch carefully to monitor what is happening in their country.²³

Another related concern of those who oppose the legalisation of active voluntary euthanasia is that it might become “. . . a generally available, acceptable, and efficient alternative to suicide”.^{24–27} A recent decision by the Supreme Court of the Netherlands not to punish a doctor for assisting in the suicide of a physically healthy patient with a “depressive disorder” would appear to support this contention.²⁸

A further variant of the “slippery slope” argument concerns the psychological consequences of legalising euthanasia. Although more nebulous, this argument is perhaps more powerful, contending that once we legalise the intentional killing of patients by their physicians, then we will inevitably change society’s perception of the sick, the elderly and the disabled and ultimately our very understanding of life and the process of dying. The argument is that in time, we will become “conditioned” to the presence of euthanasia in our midst and lose our capacity to appreciate the unknowable and inestimable value of moments in the dying patient’s life – the process of dying will be replaced by the “act” of euthanasia.¹⁶

Discussion

Arguments against active voluntary euthanasia based upon the “slippery slope” seem to present major difficulties for the pro-euthanasia lobby. For if the

“right to die” is truly a matter of *rights* and *individual autonomy*, that is, the right of individuals to choose when and how they will die, then why should this right be restricted to the terminally ill? Things *aside* from cancer and AIDS may make individuals feel that they want to die and surely rights should not be determined on the basis of whether one is terminally ill or not. Why should people who are *not* dying but who have pain, or chronic disease, or are depressed or lonely, not have the same rights to life and death? Indeed, why shouldn’t people who are perfectly healthy have the “right to die”, to insist that physicians assist them to die? If we truly support an individual’s right to choose to die then perhaps logically we must also support assisted suicide and the use of advance directives (such as living wills) by individuals who wish to indicate their desire to have their lives terminated at some point in the future.

Advocates of euthanasia address these concerns in one of two ways. For some, such as the Euthanasia Society and the AIDS Council of NSW, euthanasia should not be limited only to those who are dying but should be available to anyone who feels he would rather choose death than continue to live with what he perceives as an unacceptably poor quality of life.²⁹ For others, as outlined in the Northern Territory legislation, euthanasia should only be available to those who are terminally ill and suffering great pain. The difficulty then becomes what prerequisites should define who can choose euthanasia, and how are these to be determined. One of the concerns with the Northern Territory act is that it insists that patients must be terminally ill. Why should this be the case? What if a patient is not terminally ill in the generally accepted sense of the term, but rather is expected to die within three or five years, or is suffering pain and disability from some chronic condition (for example, diabetes) but not expected to die for many years? It is difficult to see how any limitations to euthanasia can be proposed that are logically and morally sound.

Conclusion

Issues such as active voluntary euthanasia highlight the problems we still experience as a society when addressing the uncertainties and uniqueness of human life, dying and death. There seems little doubt that the impetus for euthanasia legislation has arisen in part because of the medical profession’s failure to provide care, compassion, respect, understanding and adequate communication to those who are terminally ill. Perhaps then the real challenge that faces us now is to recognise that although we may possess the power to intervene in life and death and to legislate dying, we should instead refrain from political knee-jerk reactions, extend the scope and maturity of the euthanasia debate, and *audit* the effect of the Northern Territory legislation on patients, health care and society.

Given that this is the first instance of legalised voluntary euthanasia we do not know, as yet, whether support for voluntary euthanasia is based upon a dangerously naive view of rights, autonomy and society, or whether objections to legalising voluntary euthanasia are based on illusory, rather than real, slippery slopes. What we *do* know is that the issue is of such fundamental importance to the way in which we see ourselves, that we should address each concern openly and rationally, in open forum and free of polemics. In so doing, we must be careful to hear and consider all views, whatever their origin.

In the interim, moral issues such as euthanasia will continue to arise in clinical practice and should be addressed honestly, openly and sympathetically.³⁰ It should be recognised that there may be occasions where an individual doctor may feel compelled by conscience, respect for individual autonomy and compassion, to accede to a patient's repeated and informed request for assistance to die. In such cases, those involved must be prepared to face the closest public, professional and legal scrutiny. Our lives, our deaths, our dying and our dignity demand and deserve a more sensitive exploration and understanding of the euthanasia debate, not the political expediency delivered in the haze of a tropical May morning.

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