



LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON END OF LIFE CHOICES IN THE ACT

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Submission Cover Sheet

End of Life Choices in the ACT

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To: The Select Committee on End of Life Choices in the ACT

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Dear Committee,

I submit below my thoughts on euthanasia, assisted suicide, and end-of-life choices for your consideration.

Note – my submission is not confidential, however I would prefer that my address and contact details not be published.

Thank you.

A number of specious arguments are often put forward in favour of euthanasia and assisted suicide. While such arguments sound reasonable, they are fundamentally flawed in principle. Because euthanasia and assisted suicide usurp the role of God in deciding who will live, and who will die and when, they inevitably lead to a devaluing of human life, and a downward spiral of abuse, making it easier and easier to terminate human life (regardless of any "safeguards"). This is exactly what is now happening (despite legal "safeguards") in countries such as Canada, Belgium and Holland, that have embraced euthanasia.

Euthanasia and assisted suicide are unsafe, and always lead to a progressively expanding scope.

I would urge the ACT Parliament to learn from those countries' mistakes and not to start down the euthanasia/assisted-suicide road, but to reject all legislation leading to the legalisation of euthanasia or assisted suicide.

The irony is that with modern pain killing drugs and other medications, today's world has less reason than ever to consider such practices.

Medical treatment is the best way to manage depression - not death - and good palliative care is the most effective and most humane option for the management of terminal illness and other end-of-life situations, and the best for society as well.

Euthanasia and assisted suicide are often described as providing "death with dignity". They actually do the opposite, by reducing people to the status of livestock - to be disposed of, or to be encouraged to dispose of themselves, when no longer of use to society.

Euthanasia and assisted suicide also fundamentally alter the relationship between doctor and patient. The role of a doctor should be to preserve life - but when euthanasia or assisted suicide are in effect, a patient knows that after a point, the doctor may be more interested in killing the patient than in preserving the patient's life. This can have a massive effect on trust - between doctor and patient, and between society and the medical profession.

I have included two appendices below, about what has happened overseas in jurisdictions that have allowed euthanasia or assisted suicide.

The first article is a journalistic article in The Daily Mail, about a Dutch ethicist who used to promote euthanasia but now vehemently opposes it.

The second article is by an American academic who specialises in studying and writing about social issues.

A link to each original article is included below at the end of that article.

Yours sincerely,
David A W Miller.

Appendix-1: “Don’t Go There – Don’t Make Our Mistake”

Don't make our mistake: As assisted suicide bill goes to Lords, Dutch watchdog who once backed euthanasia warns UK of 'slippery slope' to mass deaths

- **Theo Boer, a European assisted suicide watchdog, said 'don't do it'**
- **In Netherlands euthanasia has been legal since 2002**
- **However, in six years the numbers of deaths have doubled**
- **Peers are preparing to debate the Assisted Dying Bill**
- **Bill has been promoted by Lord Falconer, a Labour former Lord Chancellor**

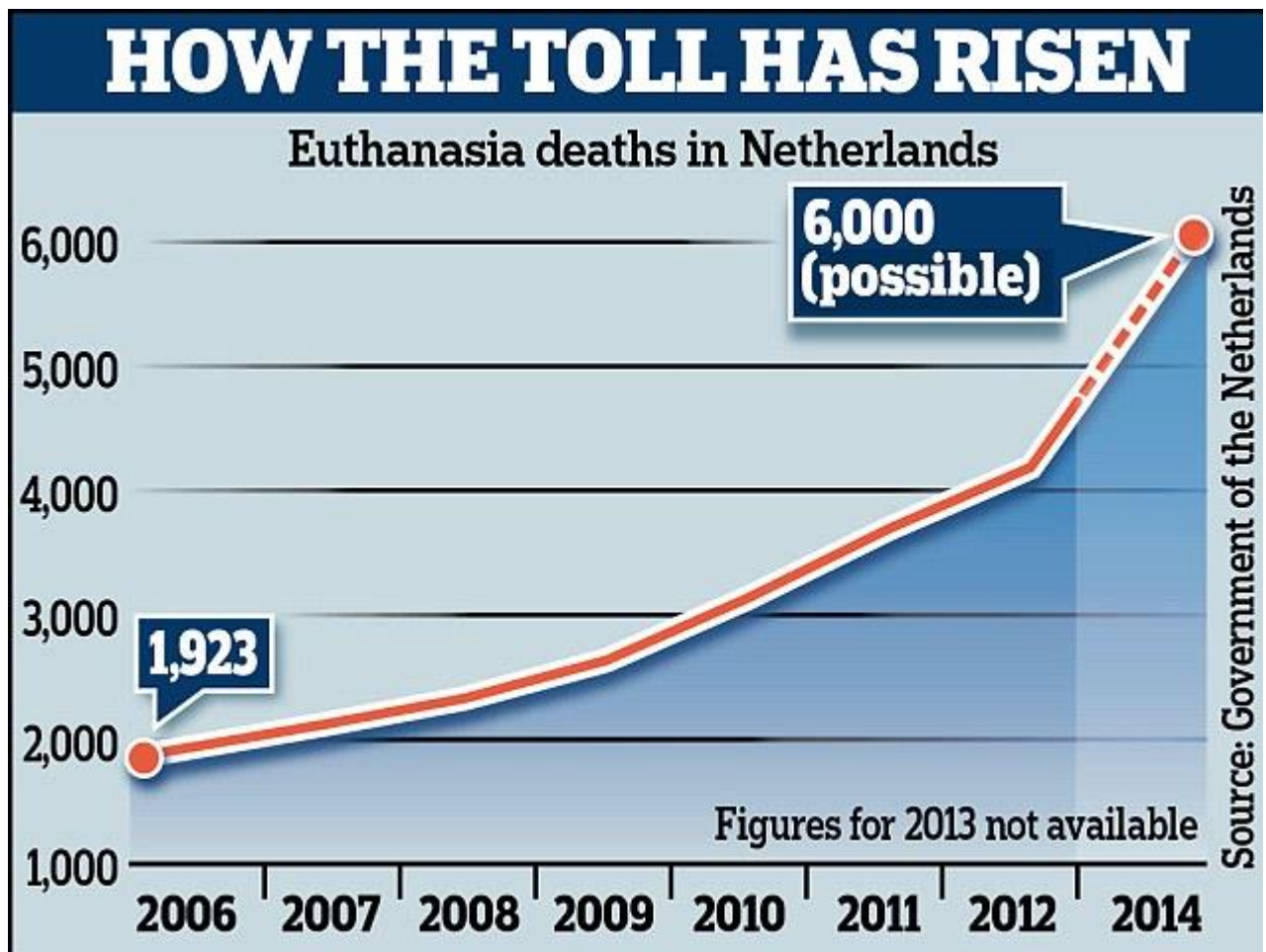
By [Steve Doughty for the Daily Mail](#)

Published: 08:40 +10:00, 10 July 2014 | Updated: 18:44 +10:00, 10 July 2014

Legalising assisted suicide is a slippery slope toward widespread killing of the sick, MPs and peers were told yesterday.

A former euthanasia supporter warned of a surge in deaths if Parliament allowed doctors to give deadly drugs to their patients.

'Don't do it Britain,' said Theo Boer, a veteran European watchdog in assisted suicide cases. 'Once the genie is out of the bottle, it is not likely ever to go back in again.'



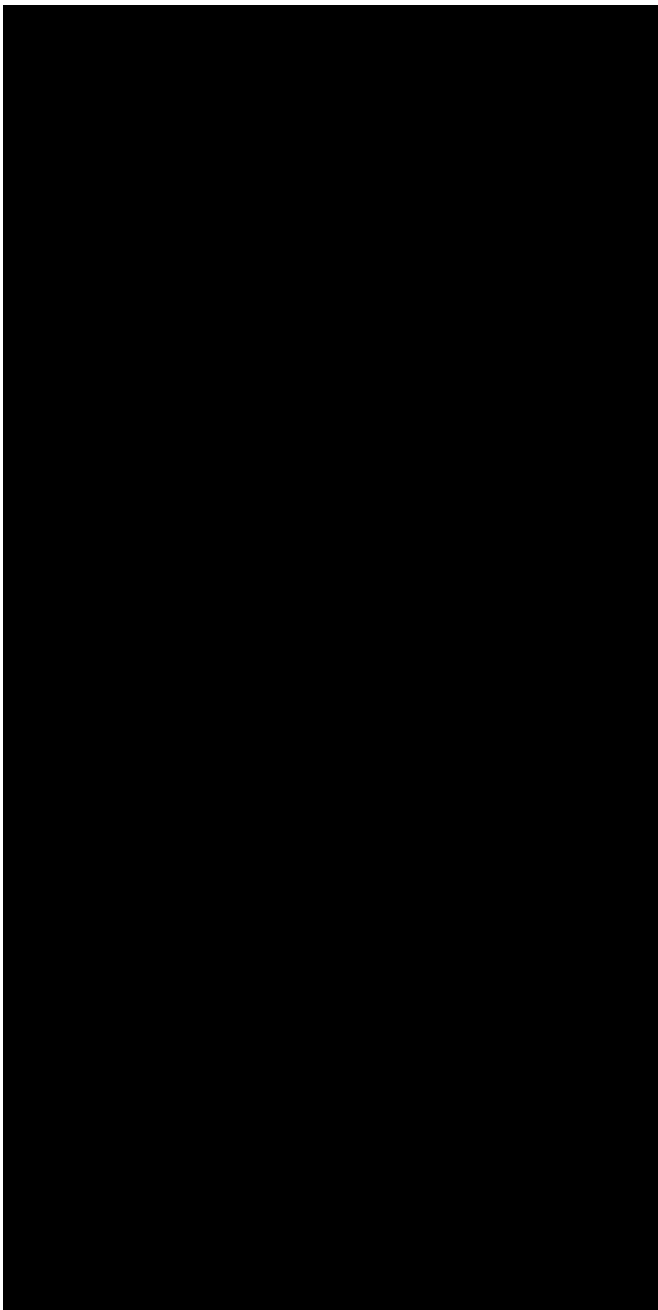
How the toll has risen: The Netherlands has seen deaths double in just six years.

His native Netherlands, where euthanasia has been legal since 2002, has seen deaths double in just six years and this year's total may reach a record 6,000.

Professor Boer's intervention comes as peers prepare to debate the Assisted Dying Bill, promoted by Lord Falconer, a Labour former Lord Chancellor.

The bill, which has its second reading next week, would allow doctors to prescribe poison to terminally ill and mentally alert people who wish to kill themselves.

Professor Boer, who is an academic in the field of ethics, had argued seven years ago that a 'good euthanasia law' would produce relatively low numbers of deaths.



Peers are preparing to debate the Assisted Dying Bill which was promoted by Lord Falconer, a Labour former Lord Chancellor.

But, speaking in a personal capacity yesterday, he said he now believed that the very existence of a euthanasia law turns assisted suicide from a last resort into a normal procedure.

A 'slippery slope' for assisted dying in Britain would mean that euthanasia would follow the same path as abortion, which was legalised in 1967.

There are now nearly 200,000 terminations a year. Anti-euthanasia campaigners and disability activists called on politicians to listen to the professor's warning.

The Paralympian, Baroness Tanni Grey-Thompson, said: 'What Dr Boer says comes as no surprise. 'An assisted dying law is playing with fire, especially when there are no safeguards in place. Lord Falconer's bill just isn't fit for purpose.'

Baroness Jane Campbell, who is a disability rights campaigner, said: ‘As happens in Holland, Lord Falconer’s bill could end up encompassing significant numbers of seriously ill people.’

Euthanasia is now becoming so prevalent in the Netherlands, Professor Boer said, that it is ‘on the way to becoming a default mode of dying for cancer patients’.

He said assisted deaths have increased by about 15 per cent every year since 2008 and the number could hit a record 6,000 this year.

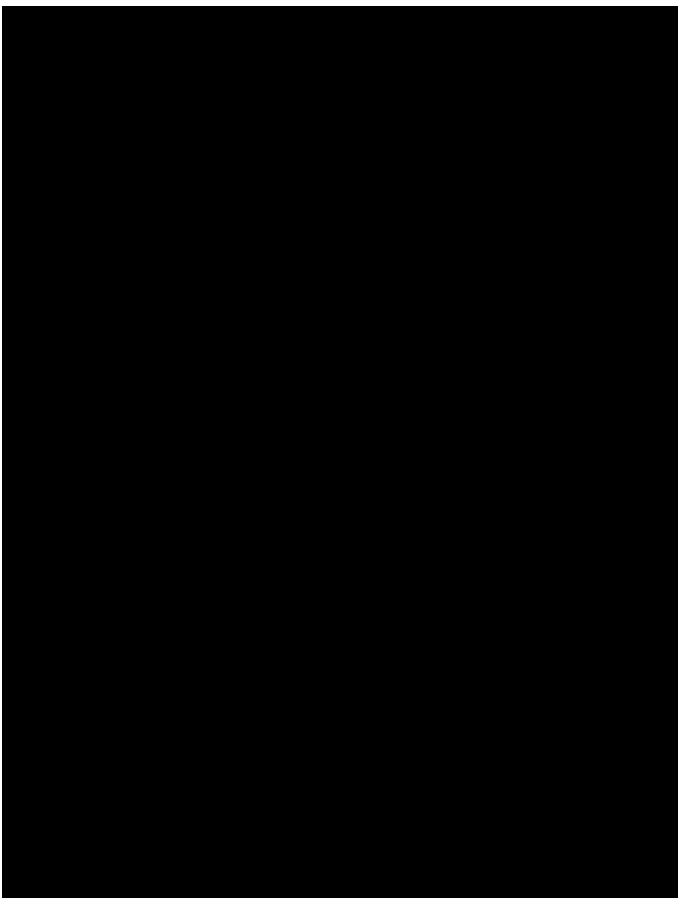
He said he was concerned at the extension of killing to new classes of people, including the demented and the depressed, and the establishment of mobile death units of ‘travelling euthanising doctors’.

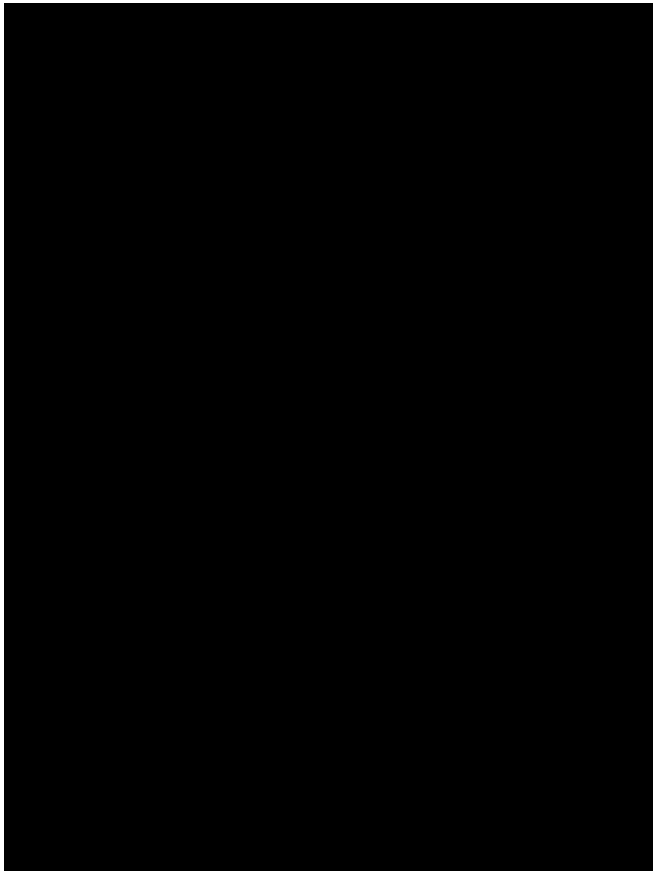
Activists, Professor Boer said, continue to campaign for doctor-administered death to be made ever easier and ‘will not rest’ until a lethal pill is made available to anyone over 70 who wishes to die. ‘Some slopes truly are slippery,’ he added.

The Utrecht University academic has been a member since 2005 of a review committee charged with monitoring euthanasia deaths. Its role includes a duty to ‘tell doctors how their actions in particular cases are likely to stand up to legal, medical and ethical scrutiny’.

Professor Boer admitted he was ‘wrong – terribly wrong, in fact’ to have believed regulated euthanasia would work.

‘I used to be a supporter of the Dutch law. But now, with 12 years of experience, I take a very different view.’





Theo Boer (above) warned of a surge in deaths which Tanni Grey-Thompson (immediately above) said came as no surprise.

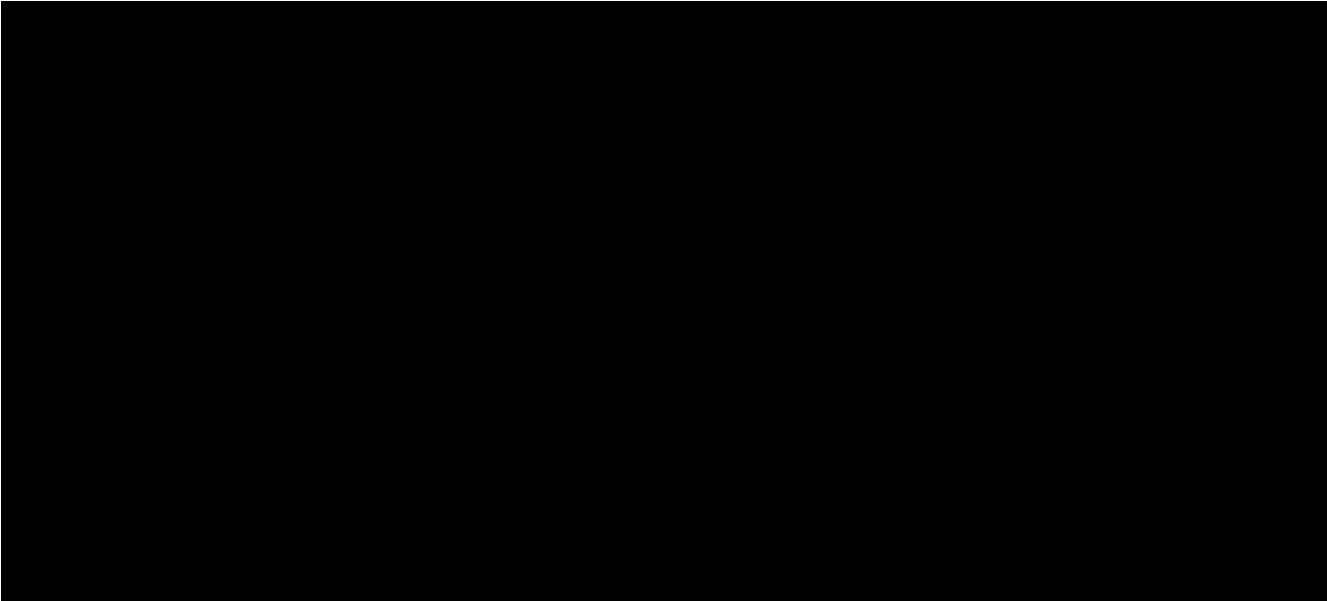
‘Whereas in the first years after 2002 hardly any patients with psychiatric illnesses or dementia appear in reports, these numbers are now sharply on the rise.

‘Cases have been reported in which a large part of the suffering of those given euthanasia or assisted suicide consisted in being aged, lonely or bereaved.

‘Some of these patients could have lived for years or decades. Pressure on doctors to conform to patients’ – or in some cases relatives’ – wishes can be intense.

‘Pressure from relatives, in combination with a patient’s concern for their wellbeing, is in some cases an important factor behind a euthanasia request. Not even the review committees, despite hard and conscientious work, have been able to halt these developments.’

The latest euthanasia figures for the Netherlands show that nearly one in seven deaths are at the hands of doctors.



Dignitas is Zurich-based organisation which helps people to kill themselves. Candidates have to fill in an official form to prove they want to commit suicide.

In 2012, there were 4,188 deaths by direct euthanasia – 3 per cent of all deaths – and 3,695 deaths by direct euthanasia in 2011.

The figures do not include deaths by terminal sedation, where patients are rendered unconscious before they are dehydrated and starved to death, an act often referred to as ‘euthanasia by omission’.

This practice accounts for more than 12 per cent of all deaths in the country.

The Netherlands is following a pattern that anti-euthanasia campaigners say has happened wherever the practice has been legalised.

Doctors in neighbouring Belgium are collectively killing an average of five people every day by euthanasia – with a 27 per cent surge in one year.

Dignity in Dying, the pressure group which supports Lord Falconer’s bill, dismissed fears that the legislation might lead to similar horrors.

Its spokesman James Harris said: ‘Lord Falconer’s Assisted Dying Bill will not legalise euthanasia, rather assisted dying for adults who are terminally ill and mentally competent, similar to legislation in Oregon which has been working safely for over 17 years and has never been extended beyond the criteria of terminal illness.’

Anti-euthanasia campaigners dispute that the Oregon law is safe or that limited numbers are dying at their own request.

Elspeth Chowdharay-Best, honorary secretary of Alert, the anti-euthanasia pressure group, said legalising assisted suicide would be like ‘stepping off a precipice’. ‘It means that you would lose the right to live,’ she said. ‘It is more serious than people realise.’

Under Lord Falconer’s bill, a terminally-ill patient would be able to ask for drugs to kill him or herself.

Two doctors would need to approve, and to be satisfied the patient was of sound mind and settled view, and had not been influenced by others.

'ASSISTED DYING: DON'T GO THERE': DUTCH ETHICIST THEO BOER'S THOUGHTS ON EUTHANASIA IN FULL (below).

In 2001 The Netherlands was the first country in the world to legalise euthanasia and, along with it, assisted suicide. Various 'safeguards' were put in place to show who should qualify and doctors acting in accordance with these 'safeguards' would not be prosecuted. Because each case is unique, five regional review committees were installed to assess every case and to decide whether it complied with the law. For five years after the law became effective, such physician-induced deaths remained level - and even fell in some years. In 2007 I wrote that 'there doesn't need to be a slippery slope when it comes to euthanasia. A good euthanasia law, in combination with the euthanasia review procedure, provides the warrants for a stable and relatively low number of euthanasia.' Most of my colleagues drew the same conclusion.

But we were wrong - terribly wrong, in fact. In hindsight, the stabilisation in the numbers was just a temporary pause. Beginning in 2008, the numbers of these deaths show an increase of 15% annually, year after year. The annual report of the committees for 2012 recorded 4,188 cases (compared with 1,882 in 2002). 2013 saw a continuation of this trend and I expect the 6,000 line to be crossed this year or the next. Euthanasia is on the way to become a 'default' mode of dying for cancer patients.

Alongside this escalation other developments have taken place. Under the name 'End of Life Clinic,' the Dutch Right to Die Society NVVE founded a network of travelling euthanizing doctors. Whereas the law presupposes (but does not require) an established doctor-patient relationship, in which death might be the end of a period of treatment and interaction, doctors of the End of Life Clinic have only two options: administer life-ending drugs or send the patient away. On average, these physicians see a patient three times before administering drugs to end their life. Hundreds of cases were conducted by the End of Life Clinic. The NVVE shows no signs of being satisfied even with these developments. They will not rest until a lethal pill is made available to anyone over 70 years who wishes to die. Some slopes truly are slippery.

Other developments include a shift in the type of patients who receive these 'treatments'. Whereas in the first years after 2002 hardly any patients with psychiatric illnesses or dementia appear in reports, these numbers are now sharply on the rise. Cases have been reported in which a large part of the suffering of those given euthanasia or assisted suicide consisted in being aged, lonely or bereaved. Some of these patients could have lived for years or decades.

Whereas the law sees assisted suicide and euthanasia as an exception, public opinion is shifting towards considering them rights, with corresponding duties on doctors to act. A law that is now in the making obliges doctors who refuse to administer euthanasia to refer their patients to a 'willing' colleague. Pressure on doctors to conform to patients' (or in some cases relatives') wishes can be intense. Pressure from relatives, in combination with a patient's concern for their wellbeing, is in some cases an important factor behind a euthanasia request. Not even the Review Committees, despite hard and conscientious work, have been able to halt these developments.

I used to be a supporter of the Dutch law. But now, with twelve years of experience, I take a very different view. At the very least, wait for an honest and intellectually satisfying analysis of the reasons behind the explosive increase in the numbers. Is it because the law should have had better safeguards? Or is it because the mere existence of such a law is an invitation to see assisted suicide and euthanasia as a normality instead of a last resort? Before those questions are answered, don't go there. Once the genie is out of the bottle, it is not likely to ever go back in again.

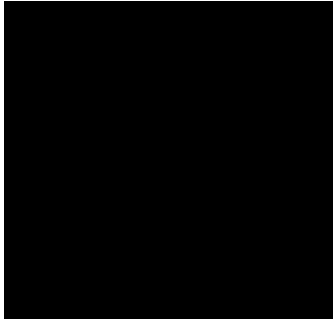
Theo Boer has been a Member of a Regional Review Committee since 2005. For the Dutch Government, five such committees assess whether a euthanasia case was conducted in accordance with the Law. In the past nine years, Prof. Boer has reviewed almost 4,000 euthanasia cases. The views expressed here represent his views as a professional ethicist, not of any institution.

Source: <http://www.dailymail.co.uk/news/article-2686711/Dont-make-mistake-As-assisted-suicide-bill-goes-Lords-Dutch-regulator-backed-euthanasia-warns-Britain-leads-mass-killing.html#ixzz4udVfE7LX>

Appendix-2: “Four Problems with Physician-Assisted Suicide”

Four Problems with Physician-Assisted Suicide

March 30, 2015 5-min read [Download Report](#)



[Ryan Anderson](#)
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Senior Research Fellow in American Principles and Public Policy

Ryan T. Anderson, Ph.D., researches and writes about marriage, bioethics, religious liberty and political philosophy.

The Hippocratic Oath proclaims: “I will keep [the sick] from harm and injustice. I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect.”^[1] This is an essential precept for a flourishing civil society. No one, especially a doctor, should be permitted to kill intentionally, or assist in killing intentionally, an innocent neighbor.

Human life need not be extended by every medical means possible, but a person should never be intentionally killed. Doctors may help their patients to die a dignified death from natural causes, but they should not kill their patients or help them to kill themselves. This is the reality that such euphemisms as “death with dignity” and “aid in dying” seek to conceal.

In 2015, at least 18 state legislatures and the District of Columbia are considering whether to allow physician-assisted suicide (PAS).^[2] Legalizing physician-assisted suicide, however, would be a grave mistake because it would:

1. Endanger the weak and vulnerable,
2. Corrupt the practice of medicine and the doctor–patient relationship,
3. Compromise the family and intergenerational commitments, and
4. Betray human dignity and equality before the law.^[3]

To understand how PAS endangers the weak and marginalized, one must understand what PAS entails and where it leads.

What Is Physician-Assisted Suicide?

With PAS, a doctor prescribes the deadly drug, but the patient self-administers it. While most activists in the United States publicly call only for PAS, they have historically advocated not only PAS, but also euthanasia: the intentional killing of the patient by a doctor.

This is not surprising: The arguments for PAS are equally arguments for euthanasia. Neil Gorsuch, currently a federal judge, points out that some contemporary activists fault the movement for not being honest about where its arguments lead. He notes that legal theorist and New York University School of Law Professor Richard Epstein “has charged his fellow assisted suicide advocates who fail to endorse the legalization of euthanasia openly and explicitly with a ‘certain lack of courage.’”[\[4\]](#)

The logic of assisted suicide leads to euthanasia because if “compassion” demands that some patients be helped to kill themselves, it makes little sense to claim that only those who are capable of self-administering the deadly drugs be given this option. Should not those who are too disabled to kill themselves have their suffering ended by a lethal injection?

And what of those who are too disabled to request that their suffering be ended, such as infants or the demented? Why should they be denied the “benefit” of a hastened death? Does not “compassion” provide an even more compelling reason for a doctor to provide this release from suffering and indignity?[\[5\]](#)

Although the Supreme Court of the United States has ruled in two unanimous decisions that there is no constitutional right to PAS, three states permit it by statute: Oregon, Washington, and Vermont.[\[6\]](#) Physician-assisted suicide and euthanasia are allowed in three European countries—the Netherlands, Belgium, and Luxembourg—and Switzerland allows assisted suicide.[\[7\]](#)

The evidence from these jurisdictions, particularly the Netherlands, which has over 30 years of experience, suggests that safeguards to ensure effective control have proved inadequate. In the Netherlands, several official, government-sponsored surveys have disclosed both that in thousands of cases, doctors have intentionally administered lethal injections to patients without a request and that in thousands of cases, they have failed to report these incidents to the authorities.[\[8\]](#)

Four Problems with Physician-Assisted Suicide

As argued in The Heritage Foundation *Backgrounder* “Always Care, Never Kill,” physician-assisted suicide is bad policy for four reasons.[\[9\]](#)

First, PAS endangers the weak and marginalized in society. Where it has been allowed, safeguards purporting to minimize this risk have proved to be inadequate and have often been watered down or eliminated over time. People who deserve society’s assistance are instead offered accelerated death.

Second, PAS changes the culture in which medicine is practiced. It corrupts the profession of medicine by permitting the tools of healing to be used as techniques for killing. By the same token, PAS threatens to fundamentally distort the doctor–patient relationship because it reduces patients’ trust of doctors and doctors’ undivided commitment to the life and health of their patients. Moreover, the option of PAS would provide perverse incentives for insurance

providers and the public and private financing of health care. Physician-assisted suicide offers a cheap, quick fix in a world of increasingly scarce health care resources.

Third, PAS would harm our entire culture, especially our family and intergenerational obligations. The temptation to view elderly or disabled family members as burdens will increase, as will the temptation for those family members to internalize this attitude and view *themselves* as burdens. Physician-assisted suicide undermines social solidarity and true compassion.

Fourth, PAS's most profound injustice is that it violates human dignity and denies equality before the law. Every human being has intrinsic dignity and immeasurable worth. For our legal system to be coherent and just, the law must respect this dignity in everyone. It does so by taking all reasonable steps to prevent the innocent, of any age or condition, from being devalued and killed. Classifying a subgroup of people as legally eligible to be killed violates our nation's commitment to equality before the law—showing profound disrespect for and callousness to those who will be judged to have lives no longer “worth living,” not least the frail elderly, the demented, and the disabled. No natural right to PAS exists, and arguments for such a right are incoherent: A legal system that allows assisted suicide abandons the natural right to life of all its citizens.

The Alternative: True Compassion and Care

Instead of embracing PAS, we should respond to suffering with true compassion and solidarity. People seeking PAS typically suffer from depression or other mental illnesses, as well as simply from loneliness. Instead of helping them to kill themselves, we should offer them appropriate medical care and human presence. For those in physical pain, pain management and other palliative medicine can manage their symptoms effectively. For those for whom death is imminent, hospice care and fellowship can accompany them in their last days. Anything less falls short of what human dignity requires. The real challenge facing society is to make quality end-of-life care available to all.

Doctors should help their patients to die a dignified death of natural causes, not assist in killing. Physicians are always to care, never to kill. They properly seek to alleviate suffering, and it is reasonable to withhold or withdraw medical interventions that are not worthwhile. However, to judge that a patient's life is not worthwhile and deliberately hasten his or her end is another thing altogether.

Citizens and policymakers need to resist the push by pressure groups, academic elites, and the media to sanction PAS.

—**Ryan T. Anderson, PhD**, is William E. Simon Fellow in the Richard and Helen DeVos Center, of the Institute for Family, Community, and Opportunity, at The Heritage Foundation.

[1] Ludwig Edelstein, *The Hippocratic Oath: Text, Translation and Interpretation* (Baltimore, MD: Johns Hopkins University Press, 1943),

<http://guides.library.jhu.edu/content.php?pid=23699&sid=190555> (accessed January 28, 2015).

[2] State legislation as of March 20, 2015: Alaska, HB 99; California, SB 128; Colorado, HB 15-1135; Connecticut, SB 668; Iowa, HF 65; Kansas, HB 2150; Maryland, HB 1021; Massachusetts, HD 1674; Minnesota, SF 1880; Missouri, HB 307; Montana, SB 202; Nevada, SB 336; New Jersey, AB 2270; New York, AB 02129; Oklahoma, HB1673; Utah, HB 391; Wisconsin, AB 67/SB 28; Wyoming, HB 119; and the District of Columbia, B21-0031. In the courts, a New Mexico appeals court will review a lower court's decision claiming to find a right to assisted suicide in the state constitution.

[3] See Ryan T. Anderson, "Always Care, Never Kill: How Physician-Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality," Heritage Foundation *Backgrounder* No. 3004, March 24, 2015, <http://www.heritage.org/research/reports/2015/03/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak-corrupts-medicine-compromises-the-family-and-violates-human-dignity-and-equality>.

[4] Neil M. Gorsuch, *The Future of Assisted Suicide and Euthanasia* (Princeton, NJ: Princeton University Press, 2006), p. 7.

[5] See Anderson, "Always Care, Never Kill."

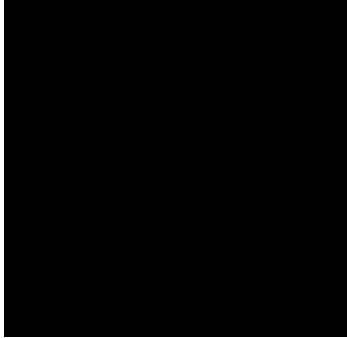
[6] See *Glucksberg and Quill: Glucksberg v. Washington*, 521 U.S. 702 (1997) (holding that "the asserted 'right' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause"), and *Vacco v. Quill*, 521 U.S. 793 (1997) (holding that because refusing treatment is logically distinct from assisting suicide, New York State's prohibition on PAS treated all patients the same and so did not violate the Equal Protection Clause). For a helpful discussion of these cases and precedents, see Gorsuch, *The Future of Assisted Suicide and Euthanasia*, pp. 8–18. Oregonians legalized PAS through Ballot Measure 16, the Death with Dignity Act in 1994; see O.R.S. § 127.800-995 (1994), which took legal effect late in 1997. Washingtonians approved Initiative 1000, the Death with Dignity Act, in 2008; see R.C.W § 70.245 (2008). In 2013, the Vermont Legislature passed the Patient Choice and Control at End of Life Act; see 18 V.S.A. § 5289 (2013). In 2009, a Montana Supreme Court decision gave physicians the ability to raise the defense of consent to a charge of violating the state's assisted suicide law; see *Baxter v. Montana*, WL 5155363 (2009). New Mexico, meanwhile, is in the middle of court proceedings over physician-assisted suicide, with a lower court having ruled in its favor, but that ruling is being appealed. Eric Eckholm, "New Mexico Judge Affirms Right to 'Aid in Dying,'" *The New York Times*, January 13, 2014, <http://www.nytimes.com/2014/01/14/us/new-mexico-judge-affirms-right-to-aid-in-dying.html> (accessed January 28, 2015).

[7] Jose Pereira, "Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls," *Current Oncology*, Vol. 18, No. 2 (April 2011), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3070710/> (accessed February 4, 2015).

[8] See also John Keown's discussion of the Netherlands in Jackson and Keown, *Debating Euthanasia*, pp. 118–128.

[9] See Anderson, "Always Care, Never Kill."

Authors



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<https://www.heritage.org/health-care-reform/report/four-problems-physician-assisted-suicide>