The Politics of Euthanasia

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Dedicated to my Mother

&

In memory of Rex Richardson

# TABLE OF CONTENTS

ABSTRACT............................................................................................................................................ VII

DECLARATION ..................................................................................................................................... VIII

ACKNOWLEDGEMENTS .................................................................................................................... IX

1 INTRODUCTION......................................................................................................................... 1

2 WESTERN RESPONSES TO END OF LIFE CHOICE................................................................. 12

   INTRODUCTION .......................................................................................................................... 12
   DEFINITIONS ............................................................................................................................... 12
   SUICIDE AND EUTHANASIA IN THE ANCIENT GREEK PERIOD ........................................... 13
   SUICIDE AND EUTHANASIA IN ANCIENT ROME ................................................................. 18
   THE INFLUX OF CHRISTIANITY ............................................................................................... 20
   THE REFORMATION AND BEYOND .......................................................................................... 24
   THE ENLIGHTENMENT PERIOD ............................................................................................... 28
   EUTHANASIA IN THE 20TH CENTURY ..................................................................................... 30
   NAZI GERMANY’S ‘EUTHANASIA’ PROGRAMME ................................................................. 32
   THE US END OF LIFE DEBATE 1940S–2007 ......................................................................... 34
   THE AUSTRALIAN END OF LIFE DEBATE: 1950S–2007 ...................................................... 45
   END OF LIFE CHOICE IN THE NETHERLANDS, BELGIUM, AND SWITZERLAND ............ 52
   CONCLUSION ............................................................................................................................... 55

3 CONTEMPORARY EUTHANASIA ISSUES................................................................................ 58

   INTRODUCTION .......................................................................................................................... 58
   THE SANCTITY OF LIFE AND QUALITY OF LIFE DEBATE ............................................... 59
   THE DIGNITY ARGUMENT ......................................................................................................... 61
   THE EXTRAORDINARY MEASURES ISSUE .............................................................................. 62
   PAIN MANAGEMENT DILEMMAS ............................................................................................. 64
   THE DOCTRINE OF DOUBLE EFFECT ...................................................................................... 68


4 EUTHANASIA AND MILLIAN LIBERALISM .............................................................. 87

INTRODUCTION ................................................................................................................. 87

LIBERTY AND HUMAN FLOURISHING .............................................................................. 87

THE PURSUIT OF PROGRESS .......................................................................................... 89

LIBERTY AND THE SLIPPERY SLOPE ............................................................................. 90

THE LIMITS OF LIBERTY – INTERESTS AND HARM ..................................................... 93

THE SOVEREIGNTY OF THE INDIVIDUAL ....................................................................... 95

LIBERTY AND TOLERANCE .............................................................................................. 98

LIBERTY AND VIRTUE ...................................................................................................... 100

LIBERTY AND HUMAN NATURE ...................................................................................... 101

THE PROBLEM OF MORAL AMBIGUITY ......................................................................... 103

THE ISSUE OF ABORTION ............................................................................................... 106

VULNERABLE PATIENTS ................................................................................................. 109

A KANTIAN ALTERNATIVE? ........................................................................................... 111

CONCLUSION .................................................................................................................... 113

5 A UTILITARIAN AND COMMUNITARIAN ANALYSIS OF AVE REFORM .............. 116

INTRODUCTION .................................................................................................................. 116

UTILITARIANISM ............................................................................................................. 116

A UTILITARIAN RESPONSE TO END OF LIFE SUFFERING ............................................ 118

UTILITY AND MORALITY ............................................................................................... 124

A LOOMING MEDICAL RESOURCE SHORTFALL ........................................................... 129

UTILITARIANISM AND EXPENDABLE INTERESTS .......................................................... 131

A COMPASSIONATE ALTERNATIVE ................................................................................. 132

A COMMUNITARIAN REBUTTAL OF LIBERAL INDIVIDUALISM .................................... 133

A COMMUNITARIAN RESPONSE TO ACTIVE VOLUNTARY EUTHANASIA ..................... 138
ERRATA

p. vi 1. 24: replace Ascension with Ratification
p. 71. 8 (footnote): replace author’s with authors
p. 321. 1: replace trial with trial
p. 321. 12: replace Professors’ with Professors
p. 411. 2: replace discernable with discernible
p. 521. 3: replace Sutton’s with Suttons’
p. 701. 1: replace who’s with whose
p. 1211. 11: replace citizen’s with citizens
p. 1261. 10: replace emphasise with emphasises
p. 1451. 7: replace accommodating with accommodating
p. 1571. 7: replace want with want
p. 1641. 5: replace venerate with vindicate
p. 1651. 8: replace Representative’s with Representatives’
p. 1661. 5: replace discrete with discreet
p. 1741. 2: replace citizen’s with citizens
p. 1771. 12: replace author’s with authors
p. 1821. 14: replace lobbyist’s with lobbyists
p. 1911. 8: replace ‘Ashcroft directive’ with Ashcroft directive
p. 1981. 10: delete and
p. 2011. 5: replace authorities with authority’s
p. 2071. 18: replace exited with excited
p. 2121. 3: replace venerated with validated
p. 2441. 12: replace relevant with vital
p. 2471. 5: replace want with want
p. 2701. 9: replace discrete with discreet
p. 2701. 12: replace discrete with discreet
p. 2781. 6: replace Nazi’s with Nazis’
p. 2871. 3: replace Ascension with Ratification
p. 2881. 1: replace lay with lie
p. 2891. 2: replace Collin’s with Collins
p. 2891. 4: replace Green’s with Greens
p. 2941. 12: replace forebear with forbear
ABSTRACT

This thesis argues that the topic of active voluntary euthanasia (AVE) has been significantly neglected in existing political studies research, despite the fact that AVE reform raises fundamental questions about the scope and application of political authority.

While this is predominantly a politics thesis in its focus, the thesis also draws when necessary on the broader scholarly literature on AVE, including literature fields such as ethics, as well as on broader public debate and the views of politicians. The thesis also examines, and engages with, the views of relevant traditional and contemporary political theorists including John Stuart Mill, Jeremy Bentham, and Amitai Etzioni. Whilst it will be acknowledged that liberal and utilitarian principles have helped shape and inform the AVE reform debate, and have useful contributions to offer, it is maintained that neither of these approaches provide a suitably comprehensive guide to policy. The thesis argues that communitarianism’s emphasis upon the communal good provides an indispensable counterbalance to potential problems that can arise with some other approaches, including excessive individualism and the uncertainties of moral subjectivism.

More particularly, it is suggested that without an ongoing commitment to the principles of self restraint and ‘other regarding’ beneficence, legalised euthanasia could pose a serious threat to the welfare of vulnerable citizens. This is a point of view that is also expressed by many religious critics of AVE and it is argued that pro-choice advocates have relied unduly upon the separation of Church and State principle to deflect a legitimate criticism. Although it is conceded that a commitment to secular liberal–democratic principles is at odds with a legislative prohibition against the popularly endorsed option of last resort (beneficent) AVE it is, nevertheless, maintained that the concerns of these and other critics should not be ignored. Indeed, an examination of various case studies highlights the importance of ensuring a balance between individual autonomy and adequate legislative safeguards. Case studies examined include John Ashcroft’s controlled substances intervention in Oregon, US Congressional action to preserve the life of persistent vegetative state patient Terri Schiavo and Australian anti-suicide / active euthanasia legislation, particularly the Northern Territory’s Rights of the Terminally Ill Act.

The conclusion of the thesis not only pulls together the key arguments regarding AVE but also highlights the insights which the AVE debate can provide for understanding broader issues in political theory and practice, particularly in regard to the rights of the individual and the responsibility of the state to legislate for the collective good.
DECLARATION

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being made available for loan and photocopying, subject to the provisions of the Copyright Act 1968.

Robert G. Richardson

16 May 2008
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1 INTRODUCTION

It will be argued throughout this thesis that the issue of active voluntary euthanasia (AVE) reform has significant political implications for citizens and policymakers alike. Yet existing euthanasia literature tends to focus upon medical, bioethics, theological, and/or legal considerations with little in the way of a dedicated political science analysis.¹ More specifically, emphasis is typically placed upon the role of the medical profession in end of life affairs, the difficulties that arise in terminal care, the ethical debate over the value of life, along with legal scrutinizing of euthanasia legislation. In response to this gap in the literature, this thesis will explore the relevant theoretical, analytical, and institutional concerns of the Politics discipline (that is of political science in the broader sense). In particular, the thesis is focussed upon issues including the rights of the individual versus that of the communal and/or greater good, the role of the Church in ‘secular’ policy affairs, and the State’s responsibility in relation to the protection of the individual and the broader public interest.

In contrast with this thesis and its political focus other commentaries, including David Cundiff’s *Euthanasia is not the Answer*, provide an indication of existing scholarship by offering advice to practitioners on countering the unresolved pain and suffering that typically motivates termination requests, along with a defence of medical and religious

¹ HR Glick has previously confirmed that there is a lack of political analysis of the euthanasia issue in *The Right to Die – Policy Innovation and its Consequences*, Columbia University Press, New York, 1992, p.6. Unlike this thesis, Glick’s commentary does not focus upon political theory and analysis as a tool to explain and critique the broader euthanasia reform policy debate, choosing instead to emphasise how policy “originated and evolved” in California, Florida, and Massachusetts and how “agenda setting” (US) right to die advocates have sought to raise the profile of the right to die issue and to achieve their objectives via the Courts rather than by purely political avenues.
arguments against the legalisation of ‘risk laden’ active euthanasia.\textsuperscript{2} Although one could draw policy defining (ethical) distinctions from Cundiff’s account and from other practitioners who have addressed the matters of patient welfare and the difficulty posed for medical professionals in placing limits on end of life requests, these discussions do not explore the issue of euthanasia from a political theory and practice perspective.\textsuperscript{3} Edited collections by James J. Walter, Thomas A. Shannon, and Kenneth R. Overberg vary in the sense that they outline competing medical analyses on euthanasia (i.e. contrasting those physicians who advocate the compassionate hastening of a beneficent death versus others who maintain that the profession’s medical obligation in the service of health and healing excludes assisted terminations or AVE) rather than focussing upon a political examination of the reform debate or one that seeks to explore the relationship between citizens and their political overseers.\textsuperscript{4} Despite the fact that there are more distinct public policy implications in palliative care specialist Brian Pollard’s call for the authorities to pursue improved pain management procedures and training rather than a AVE solution, Pollard’s\textit{Euthanasia – Should We Kill the Dying} is equally representative of the medical genre in that it focuses on treatment strategies and the indispensability of traditional (medical) ethics.\textsuperscript{5}

\begin{itemize}
\item \textsuperscript{2} D Cundiff,\textit{Euthanasia is not the Answer – A Hospice Physicians View}, Humana Press, New Jersey, 1992.
\item \textsuperscript{3} See, for example, MD Steinberg & SJ Youngner (eds.),\textit{End of Life Decisions – A Psychosocial Perspective}, American Psychiatric Press Inc., Washington, 1998. See further J Stuparich (ed.),\textit{Euthanasia, Palliative and Hospice Care and the Terminally Ill}, Australian National University, 1992.
\item \textsuperscript{5} B Pollard,\textit{Euthanasia – Should We Kill the Dying?}, Regent House, Crows Nest, 1989.
\end{itemize}
In contrast to practitioner accounts of the euthanasia issue, bioethics commentaries often place greater emphasis upon politically pertinent philosophical considerations and most particularly in relation to the scope and limits of paternal authority. This has typically involved appeals to liberal and/or utilitarian arguments as bioethicists seek to clarify their respective views on the practice of active euthanasia. Although this thesis engages with the sometime competing perspectives of leading bioethics commentators including Marvin Kohl, Helga Kuhse, James Rachels, Peter Singer, and Margaret Somerville on matters pertaining to the quality of life, self regarding rights, and slippery slope contentions, these issues are examined here with a view to exposing arguably under-analysed political or governance considerations rather than primarily upon the more immediate or patient-centric (bioethical) implications of euthanasia reform. Obviously this political science approach and its exploration of administrative oversight will not ignore the fact that (competing) ethical assumptions ultimately define the euthanasia reform debate and particularly so in relation to non-secular or theological contributions. Rather than simply critiquing the faith based natural law and spiritual views of analysts, such as Edward J. Larson, Darrel W. Amundsen, J.S. and P.D. Feinberg, and Joseph V. Sullivan, this thesis will investigate the comparatively neglected political (i.e. separation of Church and State

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and freedom of religion) implications of religiously motivated opposition to AVE reform in a ‘secular’ society.⁸

Alternatively, John Keown’s *Euthanasia, Ethics and Public Policy* goes beyond a contentious values based appraisal of euthanasia policy in order to explore the legal shortcomings in right to die legislation in the Netherlands, the Northern Territory, and Oregon.⁹ A variation on this legal analysis approach is also provided in O. Ruth Russell’s book *Freedom to Die – Moral and Legal Aspects of Euthanasia* with Russell outlining the legal justifications for AVE reform (i.e. on human rights and beneficence grounds) and offering advice regarding the means of achieving this objective.¹⁰ Although it is conceded that the politically pertinent issues of power and status at an individual, collective, and institutional level are implicit in Russell’s and other accounts of the euthanasia debate, the lack of a dedicated political science analysis is a significant oversight as calls for the State sanctioned (AVE) termination of innocent life (in the United States and Australia) effectively redefines the bounds of political/administrative authority. Indeed, it is asserted here that existing arguments on AVE reform have not exhausted the opportunity to draw additional political insights into the limits of paternal control in relation to how individual rights and obligations should be interpreted and ascribed. It is further maintained that the

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right to die issue needs to be addressed within the context of competing political assumptions, interests, and experiences, if citizens and policy makers are to make an informed and conscientious decision on the matter of State sanctioned AVE.

In laying a foundation for this political science discussion, it will be pointed out that critics of euthanasia reform tend to emphasise that a prevailing individual rights focus has enabled reform advocates to draw attention away from more pressing collective good considerations.11 Despite that allegation, their pro-choice counterparts have seen fit to contest anti-reform assumptions about the indispensability of the traditional sanctity of life principle and/or the alleged moral impropriety of euthanasia in the face of arguably futile terminal suffering.12 The second chapter of this thesis will outline and explore these conflicting interpretations from a historical perspective while the third chapter will assess and critique the increasingly complex ethical (i.e. quality of life, sanctity of life, and slippery slope) issues that dominate the contemporary euthanasia reform debate.13 Indeed, in this latter chapter it will be argued that the tendency of AVE advocates to be unduly dismissive of (slippery slope) claims about ‘desensitised’ citizens’ and legislators’ vulnerability to gradual shifts in active euthanasia practices and policy is both


inappropriate and unwise.\textsuperscript{14} Although it will be maintained that quality of life concerns must be afforded greater significance in end of life decision making, Nazi Germany’s utilitarian rationalisation of non-voluntary and involuntary terminations, more recent evidence of non-voluntary euthanasia in the Netherlands, and an increasingly inclusive right to die eligibility in Oregon (where physician-assisted suicide terminations are frequently driven by autonomy concerns rather than intractable terminal pain) will be acknowledged in order to highlight patient vulnerability to questionable terminations.\textsuperscript{15}

The tendency of AVE advocates to prioritise individual autonomy to the potential detriment of the collective good is examined in Chapter Four, with particular reference to John Stuart Mill’s \textit{On Liberty} treatise. While it will be contended that Mill’s doctrine is complicit with right to die claims, the argument for individual autonomy will be characterised as both an asset to reform advocacy and a potential threat to moral accountability. Critics have, in fact, suggested that the ‘legitimisation’ of AVE procedures may ultimately impose a liberty diminishing expectation upon all patients (in a similar medical condition) to undergo a termination.\textsuperscript{16} Moreover, they maintain that the freedom to die is a contradiction of liberty itself.\textsuperscript{17} In counter-arguing that the option of a last resort


(AVE) ‘good death’ for intolerably distressed terminal patients is more appropriately characterised as a vindication of personhood and human dignity, this chapter will differ from other (euthanasia) literature by focussing upon the conditions under which AVE is practiced rather than merely in determining if Millian liberalism permits a euthanasia option. Toward that end, the discussion will investigate whether Mill’s broadly defined harm and interest doctrines are sufficiently comprehensive to ensure that slippery slope abuses are avoided. In light of On Liberty’s express aversion to a singular universal truth, sensitivity to paternal oversight, and penchant for social experiment, it will be argued that crucial moral considerations (particularly in relation to other regarding interests) could well be undermined in a post-AVE reform environment. The alternate notion of a duty based Kantian ethic will be considered as an aside, in an attempt to establish if the interests of vulnerable patients would be better served by Kant’s categorical imperative than by Mill’s contested On Liberty principles.

While ethicists such as Peter Singer, Helga Kuhse, and Joseph Fletcher favour a utilitarian rather than strictly liberal response to euthanasia policy, Chapter Five takes the side most often adopted by the anti-AVE lobby in challenging the moral propriety of a philosophy which is dedicated to utility maximising ends. Indeed, it will be demonstrated that

\[\text{Footnote continued on the next page.}\]


19 The subject of competing rights claims without a shared moral foundation and how this issue undermines our capacity to resolve the “moral status of euthanasia” is highlighted in K Amarasekara & M Bagaric, “The Vacuousness of Rights in the Euthanasia Debate”, International Journal of Human Rights, Vol.6, No.1, Spring 2002, pp.19–44. The authors touch on a view which is also acknowledged in this thesis—namely, that communal good considerations must play a greater part in the resolution of end of life affairs.

commentators including Brain Pollard, Neil Brown, Wesley J. Smith, Germain Grisez and Joseph M. Boyle have expressed similar reservations about end of life policy being administered on the basis of potentially amoral and subjective utilitarian assumptions. Certainly it will be attested that optimal utility for some may diminish the interests of vulnerable others, as the notions of equality, the sanctity of life, and individual liberty are at risk of being traded off in pursuit of the greatest happiness. The latter portion of Chapter Five draws on the work of Amitai Etzioni, in particular, in an attempt to demonstrate that a communitarian ethic may provide a more satisfactory means of resolving right to die claims. Despite the fact that there is a distinct lack of communitarian analysis on the issue of euthanasia (AVE) reform, it will be argued that the State need not adopt a radical utilitarian policy in the management of patients or condone an extreme individual rights (liberal) ethos that is potentially damaging to vulnerable others, when there is a viable and responsive alternative that accounts for both the individual and the communal interest.

The concerns raised by communitarians about untrammelled self interest undermining the communal fabric will also feature in Chapter Six’s exploration of the Church’s role in the

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22 Some limited exceptions include H Hayry, “Bioethics and Political Ideology: The Case of Active Voluntary Euthanasia”, Bioethics, Vol.11, No.3, 1997, pp.271–276 and to a lesser extent M Bagaric, “Euthanasia: Patient Autonomy Versus the Public Good”, University of Tasmanian Law Review, Vol.18, No.1, 1999, pp.146–167. In Hayry’s article, the author speaks on a general level about the need for particular cultural conditions including a resolute commitment to equality of health care provision and individual rights before AVE can be safely practiced. That said, Hayry invokes communitarianism primarily in order to criticise its restrictive and deterministic ethos. Bagaric, on the other hand, invokes a communitarian principle by emphasising the need to ensure that the collective good prevails over potentially dangerous minority/individual AVE demands.
right to die debate. While AVE reform advocates have typically condemned clerics and Christian politicians for imposing their ‘private’ faith based views in this ‘secular’ policy issue, this discussion will argue that the religious community can make a valuable contribution to euthanasia policy. It will be acknowledged, however, that this concession does not negate the need for Church groups to afford others their right to legitimate self determination. By exposing the role played by Christian lobbyists and sympathetic politicians in the (US) Terri Schiavo affair and in the (Northern Territory) Rights of the Terminally Ill Act, it will be argued that limited (other regarding) moral oversight is preferable to unduly paternalistic and invasive legislative tactics. This discussion will draw on a variety of political science commentaries from authors including John Locke, John Stuart Mill, Brendan Sweetman, Jim Wallis, and Marion Maddox.

In light of this critique of inordinate paternalism, Chapter Seven will investigate the liberal–democratic State’s social contract obligations in order to clarify the limits of legitimate legislative oversight in end of life affairs. This objective gives rise to a number of difficulties, however, as conflicting interpretations about how legislators can best serve the individual and the collective good invite questions regarding (trustee) political representatives’ contested duty to defer to the popular will on potentially ‘risk laden’ AVE reform. It is anticipated that a case study analysis will help to resolve this dilemma with particular attention given to findings in relation to the Australian Government’s policy on suicide prevention, US Attorney General John Ashcroft’s attempt to undermine Oregon’s Death with Dignity Act and the equally ill fated federal intervention in the Terri Schiavo

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affair. In addition to relevant information drawn from Government and Court
documentation, this analysis will also refer to various political science and bioethics
commentaries from John Stuart Mill, Jean-Jacques Rousseau, Thomas Hobbes, Peter
Singer, James Rachels and John Harris.

While others such as Marion Maddox and Nina Cameron have written with insight on the
issue of the Australian Government’s intervention against the world first Rights of the
Terminally Ill Act (ROTTIA), Chapter Eight maintains that a tendency to focus on the
legislation’s historical, legal, or religious (Church–State) implications has left a gap in the
literature that requires further investigation.24 Indeed, the arguably under-analysed
Northern Territory parliamentary debate provides an opportunity to demonstrate how
liberal, democratic, utilitarian, and communitarian principles led the majority of Territory
MPs to agree on AVE and PAS reform, despite concerted opposition from amongst the
medical, Indigenous, and Church communities. While it will be conceded that the ensuing
ROTTIA had a number of flaws that needed to be rectified this discussion will,
nevertheless, argue that the Territory Parliament’s liberal–democratic status was not
undermined by its ‘good faith’ decision to acknowledge the right of terminal citizens to opt
for ‘last resort’ AVE or PAS. With the aid of Marion Maddox, John Keown, Philip
Nitschke and Fiona Stewart’s analysis of the ROTTIA issue, Chapter Nine will investigate
the federal parliamentary disallowance initiative with a view to arguing that the
Commonwealth could have fulfilled its duty of care without disenfranchising the Northern

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24 Consider, for example, M Maddox, “For God and State’s Rights: Euthanasia in the Senate”, Legislative
– The Right of the Individual or the Rights of Society”, Northern Perspective, Vol.19, No.1, 1996, pp.87–97,
GA Moens & J Trone, “Territory Rights are not State Rights”, Australia and World Affairs, No.32, Autumn
extensive account is available in Cosic, op.cit., pp.158–179 and in P Nitschke & F Stewart, Killing Me Softly,
Territory’s (intolerably distressed) terminally ill patient community. In presenting the case that the Commonwealth’s action was a disproportionate response to partially flawed legislation it will be argued that the State’s duty of care obligation extends only to ensuring that euthanasia policy adequately protects the interests of all patients.

While a preference for legislative accommodation over unwarranted paternal intervention in end of life policy making is the preeminent theme of this thesis, its originality lies not only in its political science emphasis but also in its willingness to expound upon conflicting anti-AVE reform arguments and where appropriate, to acknowledge these claims for their insight and relevance. It is not uncommon, therefore, for this thesis to read—at least in part—as an argument against legalisation. This is a deliberate tactic because a level of healthy scepticism and cautious restraint clearly must be maintained when the State sanctioned termination of innocent human beings is under consideration. Having made that point, the chapters to follow will put forward a case that disagreement over the morality of AVE need not necessarily result in the denial of end of life choice or alternatively, an inevitable or uncontrollable slide toward (post-reform) slippery slope abuses.
2 WESTERN RESPONSES TO END OF LIFE CHOICE

Introduction
Throughout the history of Western civilisation, right to die claims have been appraised on the basis of competing assumptions about power, status, and duty both at the individual and collective citizen–State level. While this discussion will acknowledge that the Western world’s Ancient Greek and Roman forerunners often saw no conflict of interest in accommodating citizens who wished to initiate a self prescribed ‘good’ death, it will be demonstrated that euthanasia was ultimately forbidden by Hippocratic medical tradition and latter day Judeo-Christian sanctity of life doctrine. The related views of leading theologians such as St. Augustine, St. Thomas Aquinas, and Martin Luther will, therefore, be explored along with the arguably more enlightened perspectives of St. Thomas More, Sir Francis Bacon, David Hume, and John Donne. More recent 20th Century responses to euthanasia will also be considered with particular references to Nazi Germany’s notorious T4 programme and to a number of subsequent US and Australian judicial and legislative rulings on beneficent killing and end of life choice. Indeed, it is anticipated that this discussion will provide a basis upon which subsequent chapters can build a more detailed analysis of the various philosophical issues that have shaped and informed the contemporary euthanasia policy debate.

Definitions
Before the historical choice in dying debate is explored, it bears explanation that the term ‘euthanasia’ is originally derived from the Greek eu-thanatos, which implies the
inducement of an easy or “good death”.\(^1\) Under this general heading there are a variety of sub-categories including *active voluntary euthanasia* (AVE) which involves the intentional and painless ‘mercy driven’ termination of a consenting rational person’s life.\(^2\) *Non-voluntary active euthanasia* (NVAE), on the other hand, refers to the termination of an incompetent individual’s existence on grounds that it is in their perceived best interests to do so.\(^3\) *Involuntary active euthanasia* (IAE) is perhaps the most controversial of practices as it involves a patient having their life extinguished without their express permission or in direct contravention of their explicit plea to live.\(^4\) In comparison with the notion of assisted dying, suicide is contrastingly defined by Emile Durkheim as applying to “all cases of death resulting directly or indirectly from a positive or negative *act of the victim himself*, which he knows will produce this result” [emphasis added].\(^5\)

### Suicide and Euthanasia in the Ancient Greek Period

The Ancient Greeks expressed conflicting views about suicide, with cities including Athens and Sparta inclined to ‘punish’ the corpse by severing the right hand and forbidding the enactment of traditional burial rituals.\(^6\) This expression of disapproval typically

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extended only to those who were deemed to have disrespected the Gods by acting out of irrational whim or without virtuous intent. It stood to reason, therefore, that citizens who ended their life in order to escape an existence of unbearable suffering were considered beyond formal reproach. One of the most influential figures in the Greek intellectual tradition, Plato (427–347 BC), was sympathetic to this logic having affirmed that it was wholly inappropriate to prolong a sick and miserable existence, for it was better to “leave the unhealthy to die”. Whilst Plato stipulated that citizens who might be considering a pre-orchestrated exit from life should exhibit due regard for Divine sovereignty, suicide was permissible in circumstances where God had sent “some necessary circumstance” including an unbearable “irremediable disgrace” or “excruciating and unavoidable misfortune”. Plato’s tutor, Socrates (469–399 BC), had similarly advised his students that life was no longer worth living when the mind or body was “worn out and ruined”. Central to this Socratic dialogue was a quality of life argument that remains pertinent even today, having contended that the most “important thing” was not just to live, “but to live well”. While Socrates was under an order of execution at the time of his own suicide, it was clearly significant that before ingesting a lethal cocktail he again saw fit to reiterate

8 ibid.
11 Plato, “Crito”, in, Plato, The Last Days of Socrates, p.86 [47e–48a]
12 ibid., p.87 [48b]
that “I should only make myself ridiculous in my own eyes if I clung to life...when it has no more to offer”.13

The Ancient Greeks’ preoccupation with preserving honour and dignity was further exemplified by Diogenes Laertius (400–325 BC) dismissive retort to crippled companion Speusippus—“if you can endure to live in such a plight as this, I decline to return your greeting”.14 The implication that individuals were wise to exit life (as Speusippus ultimately chose to do) when overtaken by suffering was similarly endorsed by Zeno (333–262 BC) the founder of Stoicism.15 Although it would appear contrary to the idea of stoic self control in the face of adversity, the elderly Zeno committed suicide in response to a broken finger, having interpreted this incident as a providential warning that his life should now be brought to an end.16 Rival Epicurean devotees’ emphasis upon an existence dedicated to the pursuit of pleasure proved equally inclined to end their lives in order to escape “pain in the body” and “trouble in the mind”.17 In particular, Epicurus (341–270 BC) affirmed that if life became “tedious” or “intolerable”, a person should flee to the “sanctuary of death” because dissolution allegedly offered the “privation of all sense”.18

13 Plato, “Phaedo”, p.197 [117a]
certain quarters including Ceos and Marseilles, the local authorities were ready to facilitate this practice by permitting disillusioned and distressed individuals the opportunity to obtain a lethal dose of hemlock.\textsuperscript{19} This potent herb was renowned for its irreversible effect on its users, with Theophrastus’s (372–288 BC) text \textit{Enquiry into Plants} advising that the “hemlock poppy and other such herbs, so compounded as to make a dose of conveniently small size” provided “an easy and painless end”.\textsuperscript{20} Citizens could either ingest the poison themselves or—if needs be—have it administered to them content in the knowledge that the nominated accomplice was immune from prosecution.\textsuperscript{21} In fact, the evidence at hand suggests that the Ancient Greeks participated in all manner of ‘beneficent’ active euthanasia procedures including voluntary, non-voluntary, and even involuntary mercy killings.\textsuperscript{22}

The legitimacy of mercy killing was ultimately called into question by Aristotle (384–322 BC) on grounds that suicide (and by implication euthanasia) violated the “right principle” of nature and constituted “an offence against the State”.\textsuperscript{23} In particular, a self orchestrated death was characterised as a blow to the economy as it destroyed an otherwise contributing member of the community.\textsuperscript{24} Individuals who extinguished their life even in order to

\textsuperscript{19} Alvarez, op.cit., p.79


\textsuperscript{21} RJ Bonner & G Smith, \textit{The Administration of Justice from Homer to Aristotle}, The University of Chicago Press, Chicago, 1938, p.196

\textsuperscript{22} I Dowbiggin, \textit{A Merciful End – The Euthanasia Movement in Modern America}, Oxford University Press, 2003, pp.2–3


\textsuperscript{24} Alvarez, op.cit., p.77
escape affliction or distress were not only condemned by Aristotle for failing to fulfil their civic duty, but also for behaving in a cowardly manner.\textsuperscript{25} A similar sense of distaste for perceived feebleness later prompted Epictetus (AD 60–138) to encourage ailing patients to maintain their respectable composure by resisting the temptation to “flatter” their physician with a plea to die.\textsuperscript{26} Elements within the medical fraternity had, in fact, already moved to discourage the practice of physicians’ administering a “fatal draught”, threatening that dishonour and ruin would befall those who betrayed their Hippocratic Oath to the Gods’ of healing—namely Apollo and son, Aesculapius.\textsuperscript{27} The intentional killing of a patient was, subsequently, characterised by Hippocratic practitioner Apuleius as an “abominable enterprise” that was wholly inconsistent with the profession’s duty to cure and not harm their patients.\textsuperscript{28} Whilst Hippocrates himself had conceded in the 5\textsuperscript{th} Century BC that there would always be those “who are troubled and ill and want to hang themselves”, the recommended response was to prescribe a ‘palliative medication’ such as “mandrake root”.\textsuperscript{29} Although Hippocratic practitioners were not expected to preserve life past reason, it was understood that a plea for release from intolerable distress was secondary to allegedly more compelling religious obligations.

\textsuperscript{25} Aristotle, op.cit., p.130 [1116a6–24]


Suicide and Euthanasia in Ancient Rome

In light of a belief that life need not necessarily be construed as a sacred gift from the Gods, Roman citizens were able to adopt a highly individualistic approach to suicide and euthanasia with the right to die extended not only to those afflicted with physical and mental ailments, but also to the healthy.\(^{30}\) With the notable exception of slaves and soldiers who were considered as non-autonomous property, suicide was widely viewed as an honourable and even courageous response to intolerable circumstances.\(^{31}\) The authorities would only intervene against citizens who set out to destroy themselves without just cause, as it was assumed that one who would lay violent hands on themselves on irrational grounds posed a potential threat to the wellbeing of fellow citizens. On other occasions, however, it is clear that individuals often had justification to end their lives in response to Roman practitioners’ inability to heal or adequately alleviate their suffering.\(^{32}\) In fact, prior to the arrival of comparatively accomplished Greek physicians such as Galen (AD 130–201), Roman householders had generally administered to their own medical needs.\(^{33}\) Those who opted instead to turn to outsiders for assistance had no better assurance of receiving safe and effective treatment, as medical services could be offered by literally anyone.\(^{34}\)

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30 Gorsuch, op.cit., p.25

31 Alvarez, op.cit., pp.80–83


The Roman world’s precarious therapeutic culture led notary Suetonius (AD 69–140) to report that citizens dreaded the prospect of a prolonged illness and would express a desire for a quick and easeful demise. For example, Julius Caesar (100–44 BC) made it known that he “loathed the prospect of a lingering end”, while Caesar Augustus (63 BC–AD 14) expressed a corresponding desire for an “easy exit” from life, having implored “Heaven” to ensure a gentle “euthanasia” death. Certainly Marcus Tillius Cicero (106–43 BC) expressed the like conviction that death was a viable alternative to intolerable torment, insisting that a “life full of pain is the thing most to be avoided” as the “wise man” recognises that it is unnecessary to “continue to the last curtain” when “the play grows wearisome”. In keeping with this pragmatic philosophy, Nero’s Chief Advisor Seneca (4 BC–AD 65) maintained that a person who “lives merely to brave out...pain, is a fool” for when “necessity” demands it, one should seek “a becoming exit” from life. The influential Roman author Pliny the Elder (AD 23–79) similarly concluded that the capacity to bring a “timely” end to a futile and tormented existence was the single most important “advantage” that “Nature” had bestowed upon humanity. This perspective was later adopted by Emperor Marcus Aurelius (AD 121–180) who assured Romans that even if the Gods existed, citizens could take their “leave of mankind” without fear of invoking Divine disfavour.

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transgressing spiritual or earthly obligations was, however, destined to be revoked by Judeo-Christian doctrine.

The Influx of Christianity

The influx of (deontological) Judeo-Christian teaching from the mid-First Century after Christ challenged the legitimacy of Rome’s previously liberal attitudes toward end of life choice.\(^{40}\) This was not without irony, as the scribe Evarestus recalled that condemned Christian converts were widely renowned for the practice of antagonising the “savage beasts” which were set against them, as they were wholly intent on gaining “a speedier release” from the “world of unjust and lawless men”.\(^{41}\) Even amongst the Church hierarchy there was a certain bravado regarding the loss of life with Ignatius (the Bishop of Antioch) stating that “I yearn for martyrdom”, whilst the soon to be martyred Polycarp (the Bishop of Smyrna) is said to have goaded his Roman tormentors to “Bring out whatever you have in mind”.\(^{42}\) In spite of this fanatical legacy, the Church eventually came to view the wilful courting of death as a direct contravention of Divine sovereignty.\(^{43}\) It is equally significant


\(^{42}\) Ignatius, “The Epistle to the Trallians”, in, Radice (ed.), op.cit., p.80 [4]. See further Evarestus, op.cit., p.128 [11]. It bears pointing out that while a number of Christians accepted or even courted martyrdom, death was considered a better alternative than the sin of renunciation or apostasy. See: DW Amundsen, *Medicine, Society, and Faith in the Ancient and Medieval Worlds*, The John Hopkins University Press, London, 1996, p.81

that the *Old Testament* commandment “Thou shalt not kill” was further interpreted as prohibiting the practice of slaying “blameless” or “guiltless” individuals. Early Church documents such as *The Didache* arguably affirm this *sanctity of life* principle, with the *Epistle of Barnabas* stipulating that we are “never” to destroy an (innocent) child “after its birth” [emphasis added]. It is clear that this principle was extended well beyond infanticide, as the AD 1st Century’s Clement of Rome referred to those who wilfully set out to “destroy themselves” as destined for the severest punishment in “Hades”.

Emperor Constantine’s subsequent (312) proclamation naming Christianity as the Roman Empire’s official religion ultimately ensured that this strict sanctity of life ethos was elevated to a place of formal recognition.

Whilst Christian theologians typically endorsed the notion that the “Holy Scripture forbids a Christian to lay hands on himself”, St. Ambrose (339–397) departed from established tradition by making a discretionary allowance for threatened maidens who were purportedly permitted to martyr themselves (i.e. commit suicide) in order to preserve their chastity. Indeed, Ambrose invoked the words of Saint Pelagia in support of this last resort measure:

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God is not offended by a remedy against evil, and faith permits the act. In truth, if we think of the real meaning of the word, how can what is voluntary be violence? It is rather violence to wish to die and not to be able.\textsuperscript{48}

In response, St. Augustine (354–430) expressed opposition to Ambrose’s situational ethics rationale, having argued that “nowhere” in the “sacred Canonical Books” was any authority given to wilfully end one’s life—even in an effort to “avoid or escape any evil” [emphasis added].\textsuperscript{49} Catholic tradition maintained that Christians should, in fact, be ready to endure the same sorts of “hardships, dangers and penalties” that Christ Himself had experienced.\textsuperscript{50} The trials of other Biblical figures, such as Job, were also held up in order to reinforce the idea that submission to earthly torment was a test of one’s faith or an opportunity to exact penance for sins.\textsuperscript{51} Ill-health, in particular, was purportedly approved of by God to test the integrity and commitment of His subjects.\textsuperscript{52} Unfortunately, this \textit{fatalistic} interpretation of ‘beneficent’ human suffering not only served to hinder choice in dying, but also much needed medical advances.\textsuperscript{53} In the absence of adequate symptom relief, the faithful were encouraged to rely first and foremost upon fasting, prayer and/or the laying on of hands.\textsuperscript{54} The concept of self determination and, indeed, self regard

\begin{thebibliography}{99}
\bibitem{49} St Augustine, \textit{Concerning the City of God against the Pagans}, trans. H Bettenson, Penguin Books, Middlesex, 1980, p.31 \[1:20\]
\bibitem{52} G Constable, \textit{Culture and Spirituality in Medieval Europe}, Variorum, Aldershot, 1996, p.10
\bibitem{53} Rhodes, op.cit., p.30
\end{thebibliography}
(arguably encapsulated in the Biblical admonition “Love your neighbour as yourself”) was henceforth sacrificed in the service of an overtly legalistic sanctity of life ethic.\textsuperscript{55}

The practices of beneficent suicide and euthanasia came under increasing scrutiny following Emperor Justinian’s 529 decree instructing \textit{all} citizens of the Empire to convert to the Christian faith.\textsuperscript{56} As a consequence of this initiative, the Church hierarchy was in a position to appeal directly to civil administrative support as a guarantor of this and other ecclesiastical dictates.\textsuperscript{57} Indeed, the clergy saw this as an opportunity to establish the sanctity of life principle as a universal standard with the 561 Council of Braga decreeing that suicides should forfeit their worldly goods and be denied a Christian burial.\textsuperscript{58} The cadaver itself was then to be disposed of at a suitably ignominious crossroad, hanging from a gibbet or impaled with a stake.\textsuperscript{59} The brutality of this practice reflected the severity of the perceived transgression, as St. Thomas Aquinas (1225–1274) asserted that suicide was contrary to the natural order (\textit{or} the instinctive desire for self preservation), contravened the creator God’s sovereign role as the only legitimate “master” over “death and life”, and was detrimental to the interests of the community.\textsuperscript{60} In the latter case, the inference that

\begin{itemize}
\item \textsuperscript{55} Galatians, 5:14
\item \textsuperscript{57} D Miller \textit{et al} (eds.), \textit{The Blackwell Encyclopedia of Political Thought}, Blackwell Reference, Cambridge, 1995, p.68
\item \textsuperscript{59} Alvarez, op.cit., p.64
\end{itemize}
suicide was an offence against one’s fellow citizens was informed by an enduring belief that people have an obligation to use their life to serve others. In turn, the community was depicted as having a reciprocal duty to discourage self-destructive tendencies, by treating afflicted individuals with compassionate care.\textsuperscript{61} Those who wished to conform to religious dictates were, thus, reliant upon the medical profession to stave off excruciating pain and suffering via often dubious treatments including gruesome blood-letting or purgative and emetic procedures.\textsuperscript{62} These unsavoury ‘remedies’ reveal that Middle Ages medical practice had made little scientific headway, with physicians relying heavily upon Ancient Greek and Roman scholarship.\textsuperscript{63} This situation remained largely unchanged until the twilight of the Middle Ages, when more advanced Middle Eastern medical texts were imported and later adopted by Western European universities.\textsuperscript{64} For the many patients who were unable to find adequate medical relief, however, supernatural ‘remedies’ including charms, amulets, incantations, and astrology were viewed as viable alternatives.\textsuperscript{65}

\textbf{The Reformation and Beyond}

Whilst the breakaway Protestant movement set out to distance itself from some of the more superstitious and rigorous obligations of the Catholic tradition, on the issue of choice in dying Martin Luther (1483–1546) did not depart entirely from established morality having

\begin{itemize}
\item \textsuperscript{61} DM Crone, “Historical Attitudes toward Suicide”, \textit{Duquesne Law Review}, Vol.35, No.1, Fall 1996, p.21
\item \textsuperscript{62} Rhodes, op.cit., pp.36–37
\item \textsuperscript{63} NF Cantor (ed.), \textit{The Encyclopedia of the Middle Ages}, Viking, New York, 1999, p.305
\item \textsuperscript{64} ibid., p.306
\item \textsuperscript{65} There was method in the seeking of supernatural cures as these initiatives were often motivated by a belief that disease was a form of punishment from God. See: M Lindemann, “Medicine and Healing”, in, HJ Hillerbrand (ed.), \textit{The Oxford Encyclopedia of the Reformation – Volume Three}, Oxford University Press, New York, 1996, p.39
\end{itemize}
maintained that those who committed suicide had succumbed to the “power of the Devil”. As Augustine had done before him, Luther reasoned that it was an affront to Divine law for a human being to intentionally “harm” themself. Even amongst more radical exponents of free religious thought, such as Benedict de Spinoza (1632–1677), suicides were condemned as being “opposed” to “nature” and “impotent in mind”. People had a clear duty to accept God’s inscrutable will, said Desiderius Erasmus (1466–1536), even when afflicted with the most “terrible maladies”. Those who were burdened with debilitating “pain” and “disease” must, said John Calvin (1509–1564), learn to endure their predicament “with a peaceful and grateful mind”. Indeed, the alternate option of a self appointed death was depicted as imposing a far more devastating burden upon those involved, as suicide or self-murder—as it came to be known—was widely regarded in both Catholic and Protestant theological circles as an accursed and damnable practice.

The implication that the State had been ordained by God to defend the sanctity of life underwent a secular conversion thanks to Immanuel Kant (1724–1804). Although Kant echoed the principle sentiment of the clergy, he did so without reverting to religious

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71 Crone, op.cit., p.23
justifications, having argued that even a life of abject misery and “the most excruciating pains” and “irremediable bodily suffering” did not imbue a person with the right to end their life.\(^72\) Kant’s opposition was based in part on an Aristotelian conviction that every human being had been “placed in this world...for specific purposes” and that by prematurely terminating their life, they would necessarily fail to meet their obligations.\(^73\) According to this reckoning, the suicide demonstrated not only an attitude of disregard for others but also demeaned the sacred notion of personhood by relegating their life to that of a mere “thing”.\(^74\) Kant explained that this was an unforgivable failing as “a man is not a thing that is to say, something which can be used merely as a means, but must in all his actions be always considered an end in himself”.\(^75\) Although those who sacrificed their life in order to uphold a legitimate moral duty (owed, for example, to others) were deemed commendable, Kant maintained that the deliberate pursuit of death on grounds of personal interests alone was unacceptable.\(^76\)

In contrast to a religious or Kantian duty-based ethic, a growing interest in Ancient Greek and Roman literature helped reignite debate in favour of beneficent suicide and euthanasia. Whilst natural law exponents characteristically resolved that any such undertaking


\(^{73}\) I Kant, “Duties Toward the Body with Regard to Life”, in, J Donnelly (ed.), *Suicide – Right or Wrong?*, Prometheus Books, New York, 1990, p.52

\(^{74}\) Collins, op.cit., p.147 [27:372–373]


\(^{76}\) Additional analysis of Kantian thought is provided in Chapter Four.
contravened the instinctual predilection to self preservation, Sir Thomas More (1478–1535) counter-argued that an intolerably burdened individual had a right to terminate their life of “misery”, either by starvation or via a lethal prescription of a (sleep inducing) soporific. Sir Francis Bacon (1561–1626) maintained that the medical profession, in particular, had a humanitarian duty to ensure that intolerably afflicted patients’ experienced a dignified and “easy passage” out of life. This compassionate ideal was also explored in John Donne’s (1573–1631) posthumous publication entitled Suicide, with the author asserting that “the law of nature inclines and excuses” tormented souls from their burdensome existence. It was “not always meritorious or obligatory” to save the life of one who was “willing to die” added Donne, particularly if an individual deemed that the continuation of their life was no longer of any benefit. The idea that “Death is better than a bitter life” similarly inspired fellow Anglican clergyman Robert Burton (1577–1640) to direct traditionalists away from their purportedly “rash and rigorous” response to last resort suicide. Indeed, these more liberal (freedom of choice) perspectives were indicative of a movement that favoured reason and pragmatism over contentious and stifling faith based dictates.


80 ibid., p.62

The Enlightenment Period

Western academia’s growing sense of alienation and mistrust of traditional authority ensured that a defining characteristic of the 18th Century Enlightenment was an antagonism toward superstition and custom in preference to freely chosen secular ‘reason’. During this period of critical liberal inquiry, scholars challenged a variety of longstanding beliefs including the idea that suicides were possessed by the Devil in favour of the scientific alternative that they were actually victims of mental illness. Unfortunately, this ‘diminished responsibility’ thesis failed to dissuade clerics such as John Wesley (1703–1791) from perpetuating the idea that the act of “self-murder” was a “horrid crime” that warranted the lifeless body being “hanged in chains”. This reference to chains was, of course, entirely antithetical to the Enlightenment movement’s commitment to the pursuits of liberty and human dignity. Others such as David Hume (1711–1776) were, thus, inclined to defend enlightenment principles on related utilitarian grounds, having reasoned that suicide was an “innocent” and a “laudable” act because “no man ever threw away life while it was worth keeping”. In fact, Hume claimed that it was a kind of “blasphemy” to condemn people for having defied the “general laws” of the universe, simply because they had embraced the right to terminate their life. This unorthodox perspective extended to

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86 ibid., p.9 & p.17
the more radical assumption that a suicide not only entered into death of their own volition, but “equally from the hands of the deity”.  

Religious arguments in favour of end of life choice were ultimately eclipsed by secular rationales in the 19th Century, with Arthur Schopenhauer (1788–1860) proposing that when “the terrors of life counterbalance the terrors of death”, one could not be condemned for choosing the latter option. As a critic of religious absolutism, fellow philosopher Friedrich Nietzsche (1844–1900) concurred that if a person was deteriorating into a state of “slow exhaustion and dissolution”, the “wholly natural” urge to commit suicide would represent “a victory for reason”. To deny such a one the opportunity to die “at the right time”, said Nietzsche, was an act of “cruelty”. Other commentators, including S.D. Williams, mimicked earlier assertions that physicians had a particular obligation to provide a “quick and painless death” for patients who were enduring the unresolved “tortures” of “lingering disease”. The “alleviation” of intolerable pain, Williams claimed, was the “greatest service” that one could render to a suffering person. An appeal to mercy was by no means the sole motivation for the termination of the afflicted, however, as Charles Darwin’s influential evolutionary theory challenged the customary commitment to succour

87 ibid., p.13. See further I Samuel, 2:6


90 ibid., p. 48 [88]. See further F Nietzsche, Thus Spake Zarathustra – A Book for All and None, T Fisher Unwin, London, 1899, p.98.


92 ibid., p.231
the sick on grounds that the early demise of “the weak in body or mind” countered the “bad effects” of these individuals “surviving and propagating their kind”. Indeed, Darwin made a particular point of berating so called “civilised men” for striving to sustain the lives of hopelessly feeble individuals. In so doing, active euthanasia acquired a degree of scientific respectability as defective individuals could now be categorised as an obstacle in the quest for evolutionary (human) perfectibility. Similarly, if the process of natural selection was broadly beneficial it stood to reason that humanity should actively contribute to its realisation. Longstanding moral assumptions about the sanctity of life were henceforth open to renunciation or manipulation on grounds of a secular scientific (utilitarian) ethos.

**Euthanasia in the 20th Century**

The 20th Century heralded renewed public interest in addressing the problem of untrammelled suffering, for despite the previous Century’s discoveries of pain relieving synthetic morphine, codeine, and aspirin, some terminal patients still could not be adequately palliated. This unfortunate state of affairs failed to sway the mainstream medical fraternity’s resolve against active euthanasia, however, with a turn of the Century *Journal of the American Medical Association (JAMA)* article re-affirming that physicians should only be engaged “to save life not take it”. It was further advised that any physician who was prepared to “sacrifice himself” to the practice of killing patients not only contravened the Hippocratic ‘do no harm’ principle, but also risked being labelled as a

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medical outcast. The British Medical Journal (BMJ) was equally critical of practitioners who advocated a euthanasia option, describing them as “crank[s] of a particularly noxious type”. The BMJ went on to accuse lobbyists, in particular, of setting out to degrade the role of physicians to the unsavoury position of public “executioners”.

Despite the mainstream medical profession’s commitment to preserve life, Dr. Harry J. Haiselden’s (November 1917) decision to allow a tormented (grossly deformed) microcephalic infant to die was supported by a number of the US physician’s colleagues. Whilst Haiselden further conceded that interim pain relieving medication might shorten the dying process, he was buoyed by the fact that a Chicago Court had recently acquitted him (in July) for the death of a female microcephalic infant on the understanding that Haiselden had not intended to kill the patient, but had only sought to relieve the child’s pain. This ruling was plainly significant as it demonstrated a willingness to distinguish between an intended (active euthanasia) termination and that of an unintended (doctrine of double effect) death resulting from an effective pain management intervention. Some eight years after the Haiselden affair, fellow US practitioner Harold Blazer was also thrust into the national spotlight after being charged with the intentional (mercy) killing of his invalid, 


97 ibid., p.639

98 “Doctors Back Haiselden”, New York Times, 16 November 1917, p.4


100 Please refer to Chapter Three for an overview of the doctrine of double effect.
adult daughter. At the subsequent trial, the defence attorney’s emphasis upon the deceased having “no place in the scheme of life” and of being “better off dead than alive”, aroused sufficient Juror sympathy for Blazer to escape conviction.\textsuperscript{101} Although it was deemed contrary to the traditional (Judeo-Christian) sanctity of life ethic and to prevailing Hippocratic interpretations, this sympathetic ruling demonstrated the Court’s preparedness to appraise beneficent active euthanasia as a pragmatic and compassionate (last resort) solution to intolerable suffering.

\textbf{Nazi Germany’s ‘Euthanasia’ Programme}

While some physicians were prepared to risk imprisonment in order to serve the perceived best interests of their patients, Nazi Germany’s strictly utilitarian euthanasia programme highlighted the potential risks associated with State sanctioned terminations. Indeed, the Nazis had been heavily influenced by Professors Alfred Hoche and Karl Binding’s book \textit{The Release of the Destruction of Life Devoid of Value} which argued that there were sound economic reasons for the extermination of ‘burdensome’ citizens.\textsuperscript{102} More specifically, it was intended that the systematic termination of the nation’s so called “useless eaters” and unproductive “human ballast” would serve to reduce healthcare costs and thereby liberate precious resources to be utilised elsewhere.\textsuperscript{103} In the knowledge that this was an emotive argument, Hoche and Binding envisaged that State sanctioned active euthanasia could be

\textsuperscript{101} “Get Jury for Slayer of Child-Woman”, \textit{New York Times}, 7 November 1925, p.3


rationalised under the guise of “a pure healing action”. The list of proposed ‘beneficiaries’ included the terminally ill, the insane, the mentally retarded, and deformed children. In the first instance, medical staff were encouraged to let ‘nature’ take its course by disregarding the well-being of these typically dependent individuals. In time, this practice was superseded by more pro-active measures including the co-opting of selected physicians to provide a so called “merciful death” to psychotic and a variety of other “incurable” patients. For example, under the title of the Tiergartenstrasse (T4) programme, citizens afflicted with conditions such as Multiple Sclerosis, Huntingtons Disease, Parkinsons Disease, and epilepsy were deemed as legitimate non-voluntary and involuntary euthanasia candidates.

In support of a more extensive Nazi ‘euthanasia’ programme, medical practitioners across the country were ordered to register the names of their physically deformed or mentally defective newborns. This scheme was further extended in 1941 to incorporate children up to 17 years of age. It was intended that these individuals would eventually undergo compulsory admission to ‘Children’s Specialty Institutions’ where their lives would be

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105 Lifton, op.cit., p.46

106 ibid., p.48


108 Lifton, op.cit., p.56


terminated via coma inducing luminal tablets, toxic gas, or injection. The physicians involved would falsify the patient’s death certificate stating that the deceased had expired from a condition that was consistent with their known ailments, or, that their death had come from a sudden illness such as an infectious disease or a heart attack. In an attempt to placate the concerns of distressed family members, medical staff would typically advise that the victim’s death represented “a release” from their suffering. The full magnitude of this unscrupulous policy only became apparent after the War, when it was estimated that as many as 275,000 people had been summarily put to death. Since that time, anti-euthanasia campaigners have routinely cited this abuse of power to highlight so called slippery slope concerns that legalised active euthanasia could ultimately be a precursor to all manner of non-voluntary and involuntary Nazi-like abuses.

The US End of Life Debate 1940s–2007

Despite the fact that active euthanasia remained as an illegal practice in the United States, a number of ‘mercy killing’ cases brought before the Courts during the 1940s were dealt with in a relatively sympathetic manner. In 1941, for example, The New York Times reported that Louis Repouille had been handed a suspended sentence after admitting using chloroform to induce the compassion driven death of his blind, imbecile, 13 year old son.

111 Lifton, op.cit., p.55
112 ibid., p.74. See further G Sereny, Into that Darkness – From Mercy Killing to Mass Murder, Andre Deutsch, London, 1974, p.58
113 Mitscherlich & Mielke, op.cit., p.103
115 Please note that the slippery slope debate will be addressed in Chapter Three.
This was by no means an isolated incident as the following year Edith Reichert of Brooklyn was brought before the Courts for having killed her mentally ill 29 year old brother (allegedly) in order to “put him out of his misery”. In spite of a not guilty ruling, the Judge concluded that Reichert was suffering from a mental disorder and ordered that she be incarcerated in a State hospital for a period of psychological observation. Similar mental health assumptions were made in 1949 about 21 year old Carol Ann Paight after being brought to trial for having killed her terminally ill father. Prior to deliberation, the Judge informed members of the Jury that whilst it remained conceivable that Paight’s underlying motive may well have been “pure or kindly”, US law did not condone the killing of innocent citizens. Irrespective of the Judge’s directive, The New York Times reported that the Jury’s verdict of not guilty (on grounds of temporary insanity) was met with an “outburst of cheers” throughout the courtroom. Shortly thereafter, Dr. Herman N. Sander maintained that his conscience was “clear” in relation to a charge that he had intentionally killed terminal cancer patient Abbie C. Borroto. Despite the seriousness of this allegation, the defendant reportedly enjoyed the support of a “large number of doctors, nurses [and] patients” who had come forward to testify as “character witnesses”.


119 “Carol Paight Acquitted as Insane at Time She Killed Ailing Father”, New York Times, 8 February 1950, p.24

120 ibid., p.1


verdict of not guilty was announced, crowds awaiting the decision once again expressed their delight with a rousing burst of applause. Borrotto’s long-suffering husband also welcomed Sander’s acquittal, telling reporters that it was “the most heart-warming news I have ever received”.\footnote{ibid., p.23} This victory was ultimately bitter-sweet, however, as the New Hampshire Board of Registration later moved to revoke the \textit{acquitted} practitioner’s medical licence.\footnote{Humphry & Wickett, op.cit., p.47}

The decision to strike the arguably tainted Dr. Sander from the State medical register was not particularly surprising, given the American \textit{and} World Medical Association’s strict prohibition against the wilful termination of a patient’s life under “any circumstances”. Indeed, it was maintained that active euthanasia was “contrary” to established medical ethics, the public interest, and to the indispensable right to life principle that underpins civil rights.\footnote{“Organisation Section Official Notes – World Medical Association”, \textit{Journal of the American Medical Association}, Vol.143, No.6, 10 June 1950, p.561} The American Physicians’ Association also expressed its opposition to the practice of mercy killing, stating that physicians should not be imbued with “the power of life and death over individuals who have committed no crime except that of becoming ill or [of] being born ill”.\footnote{“Mercy Death Ban Urged on Doctors”, \textit{New York Times}, 27 November 1948, p.9} Whether the majority of practitioners believed themselves bound to uphold this absolutist ideal remains debatable, however, as a 1961 University of Chicago survey found that 61 per cent of physicians believed that their colleagues had taken active steps to end futile or intolerably distressed lives.\footnote{Humphry & Wickett, op.cit., p.76} In 1966 the \textit{Journal of the
American Medical Association (JAMA) published an equally provocative William P. Williamson article outlining the “humanitarian arguments” in favour of euthanasia, and posing the question—“Should we not be able to do something for a loved one that we can do for a dog?” As the turbulent 1960s drew to a close, JAMA contributor Robert H. Williams pondered how it could be that “We recognise justifiable homicide in self-defence, in capital punishment, and in extensive wars” and yet, think it entirely unethical to terminate a life of “tremendous mental and physical suffering”.

An indication of the strength of practitioner sympathy for enhanced end of life choice was again flagged in a January 1970 edition of JAMA, with the journal reporting that a survey of 418 Seattle doctors indicated 31 per cent approved of AVE. Indeed, Dr. Walter Sackett’s 1971 Southern Medical Journal article entitled “Death with Dignity?” asserted that it was far better to permit the “hopelessly ill to die with dignity” rather than striving to keep them alive in “a meaningless state”. A meeting of American Medical Association (AMA) delegates in 1974 was, however, not about to entertain the idea of going beyond this proposed passive euthanasia practice (i.e. the omission or suspension of medical treatment in the knowledge that this decision is likely to hasten a patient’s death) having resolved that:

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The intentional termination of the life of one human being by another—mercy killing—is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association [emphasis added].

In spite of this unambiguous statement, a series of Gallup, Institute of Life Insurance, and National Opinion Research Centre polls during the 1970s indicted that as many as 62 per cent of Americans agreed with last resort AVE. This expression of support for end of life choice was perhaps most dramatically exemplified by the US based Euthanasia Education Council which had grown from a humble membership of 600 people in 1969, to more than 300 000 by 1975.

It is clear that the widely publicised case of 22 year old New Jersey patient Karen Ann Quinlan was something of a catalyst for growing debate over the merits of merciful euthanasia. By way of background, in April 1975 Quinlan had slipped into a persistent vegetative state (PVS) after having failed to draw breath over two fifteen minute intervals. The subsequent medical prognosis was that Quinlan would “never be restored to cognitive or sapient life”. A more extensive explanation of this condition is provided by the American Academy of Neurology, having characterised the PVS patient as one who shows “no evidence of awareness of self or environment” and demonstrates “an inability to interact with others”. Whilst PVS patients may “blink or smile”, there is no indication of


134 Humphry & Wickett, op.cit., p.100


136 ibid, p.56
any “sustained, reproducible, purposeful or voluntary behavioural responses to visual, auditory, tactile or noxious stimuli”. Following consultations with physicians, family members, and the clergy, the patient’s father and guardian Joseph Quinlan concluded that it would be in his daughter’s best interests if the life sustaining artificial respiration currently being utilised upon her was withdrawn. Once again, this proposal tended towards passive euthanasia as it involved the omission or suspension of treatment in the knowledge that it could hasten the demise of a futile life. While passive euthanasia is recognised today as a timely expression of effective palliative care, in Quinlan’s case the hospital refused to heed this cessation of life support treatment request, forcing the dispute into the Courts. After much legal wrangling, the New Jersey Supreme Court’s decision to uphold Joseph Quinlan’s petition met with a sigh of relief amongst euthanasia advocates and pointed criticism from the likes of ethicist Paul Ramsey, who later argued that this judgement had imbued an “extraordinary extralegal power” to impose death upon a non-consenting person. This was not strictly the case, however, as the pre-PVS Karen Quinlan is reported to have stated on no less than three prior occasions that she did not wish to have extraordinary medical measures brought to bear in order to sustain a futile and irrecoverable existence.


138 Steinbock & Norcross, op.cit., pp.59–60

139 J Fletcher, “Ethics and Euthanasia”, in, DJ Horan & D Mall (eds.), Death, Dying and Euthanasia, Aletheia Books, Frederick, 1980, p.293


141 P Ramsey, Ethics at the Edges of Life – Medical and Legal Intersections, Yale University Press, New Haven, 1978, pp.293–294

The boundaries of US law and, indeed, end of life ethics were again tested after 25 year old Nancy Cruzan suffered a near fatal car accident in 1983. Although Cruzan experienced such severe brain damage that she would never again be rendered conscious, medical technology had once more been engaged to ensure that the patient’s vital organs were maintained with artificial hydration and nutrition.\(^{143}\) After four years without sign of improvement in the patient’s condition, Cruzan’s parents implored the Missouri Supreme Court to order the removal of her life sustaining feeding tube. Whilst a lower Court was prepared to grant this request, on appeal, the Missouri Supreme Court rejected this ruling, claiming that there had to be “clear and convincing evidence” that Cruzan had expressed a desire to forgo treatment. Despite the fact that the Judiciary had previously exhibited support for the right of competent patients to refuse life sustaining interventions, the Supreme Court ruled against Cruzan’s parents on grounds that there was no Constitutional prohibition against the State restricting the rights of surrogate decision makers. Only after a number of Cruzan’s family and friends provided sworn testimony to the fact that the patient would not have wished to have been maintained in a persistent vegetative state, did a Missouri Court finally adjudicate in favour of removing the feeding tube. Cruzan died 10 days later on 26 December 1990.\(^{144}\) In response to Cruzan’s death, the *San Francisco Chronicle* typified the concerns of many US pro-life advocates in commenting that the Judiciary’s enabling verdict represented “a warning bell about American attitudes towards the disabled”.\(^{145}\) On the other hand, this outcome was a clear victory for those who had

\(^{143}\) Cosic, op.cit., p.140


argued that it was cruel and immoral to indefinitely sustain incurable PVS patients who lacked any discernible quality of life. In both the Cruzan and Quinlan cases, conflicting interpretations about the State’s duty of care toward incompetent citizens and the rights of guardians to defend the wishes of these arguably demoralised patients were resolved in favour of a compelling compassion based agenda.\(^{146}\)

The end of life debate took shape in the 1990s with US pathologist Dr. Jack Kevorkian gaining national and international notoriety for allegedly assisting in the deaths of 130 terminally \textit{and} non-terminally ill people.\(^{147}\) It was reported that Kevorkian had offered this unique ‘service’ to patients who had become convinced that they would never again realise a satisfactory quality of life.\(^{148}\) Although the authorities had moved to prosecute Kevorkian for involvement in these outlawed procedures, this elusive practitioner managed to escape conviction on no less than four separate occasions.\(^{149}\) Kevorkian’s downfall was, however, sealed in 1998 after appearing on US television’s \textit{60 Minutes} programme injecting Lou Gehrig’s disease sufferer Thomas Youk with a deadly barbiturate.\(^{150}\) While the soon to be convicted felon had acted strictly in accordance with the patient’s wishes, Kevorkian was

\(^{146}\) See further Chapter Seven’s discussion on the State’s role in end of life affairs and, in particular, the Terri Schiavo incident.

\(^{147}\) WJ Smith, \textit{Culture of Death – The Assault on Medical Ethics in America}, Encounter Books, San Francisco, 2000, p.95


\(^{150}\) Smith, op.cit., p.100
charged with Youk’s (second-degree) murder—resulting in a gaol term of 10 to 25 years.\textsuperscript{151}

Amongst others in the medical profession, Edmund D. Pelligrino described Kevorkian’s “socially disastrous” assisted suicide and active euthanasia practices as demonstrative of “a shocking disregard for the most elementary responsibilities of a physician to a patient”.\textsuperscript{152}

Having himself been exonerated for assisting in the suicide of a leukaemia patient in 1990, Dr. Timothy E. Quill expressed a different perspective by contending that it was an indictment on modern medical practice that it had been found “so lacking” that Kevorkian’s “superficial, bizarre approach to death” was deemed preferable—by well over 100 patients—to conventional pain management options.\textsuperscript{153}

Whilst the Kevorkian case aroused considerable public sympathy for a more responsive policy in end of life affairs, American voters had previously been reluctant to enshrine right to die legislation with mercy killing initiatives in Washington State (1991) and in California (1992) failing to win popular endorsement.\textsuperscript{154} Certainly one could argue that these citizens had been fearful that the legalisation of physician-assisted suicide (PAS – which involves a doctor providing a patient with the necessary drugs to self administer their own death) or AVE would pose an unacceptable risk to vulnerable patients.\textsuperscript{155}

\textsuperscript{151} Kevorkian has since been released on parole (in June 2007) vowing to lobby in favour of the right to AVE. See further K Landers, ‘Dr. Death’ Jack Kevorkian released from US Prison, Australian Broadcasting Corporation (ABC), News Online, 2 June 2007, viewed 23 July 2007, <http://www.abc.net.au/news/stories/2007/06/02/1940512.htm> & Dowbiggin, op.cit., p.xi


\textsuperscript{153} Quill, op.cit., p.125

\textsuperscript{154} ibid., pp.152–153

was, however, an exception to the rule as a small (51 per cent) majority of Oregon residents bucked the national trend by voting in favour of legalised PAS for terminally ill, rational adults in November 1994. More specifically, Oregon’s *Death with Dignity Act* (*DWDA*) requires that PAS candidates must be 18 years and over and be suffering from a terminal illness that will result in their death within six months. Patients also need to have made two oral requests for PAS (over not less than a 15 day period) and provide a signed and witnessed declaration to this effect. Two physicians are then required to “confirm the patient’s diagnosis and prognosis” and, be satisfied that the candidate is in a rational, non-mentally impaired state. The Oregon authorities also require that attending physicians “inform the patient of feasible alternatives to assisted suicide including comfort care, hospice care, and pain control”. Despite these safeguards, the enactment of the *DWDA* was delayed after a Federal District Court injunction was upheld. In particular, the injunction alleged that the Act infringed protections guaranteed under the US Constitution and lacked adequate safeguards for those persons who might be described as posing “a danger to themselves”. Following the Ninth Circuit Court of Appeals decision to lift this injunction in October 1997, the Oregon Government petitioned the State’s citizenry (in November) to adjudicate on the Act’s repeal. The result was that a more conclusive 60 per cent majority of voters expressed support for retaining the legislation.

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159 Department of Human Services, *Physician-Assisted Suicide: FAQ’s about Physician-Assisted Suicide*. 
Oregon’s Department of Human Services (2006) *Eighth Annual Report on the Death with Dignity Act* advises that there have been some 292 documented PAS deaths since the Act’s implementation.\(^{160}\) Whilst Oregon’s PAS figures remain low (at around 1 in 800 deaths), the pro-life Administration of George W. Bush has taken a particularly dim view of the *DWDA* having challenged the legality of Oregon physicians utilising federally controlled medications to terminate the lives of patients under the *Controlled Substances Act*.\(^{161}\)

Although this is an issue that will be addressed in further detail in Chapter Six, suffice to say that the United States Court of Appeals for the Ninth Circuit rejected Washington’s “unilateral attempt to regulate general medical practices historically entrusted to State lawmakers”, in January 2006. The Court further maintained that the Federal action had effectively “interfere[d] with the democratic debate about physician-assisted suicide”.\(^{162}\) In spite of the fact that this Judicial rebuff exposed the lengths to which some in Government were prepared to go in ensuring paternal oversight in end of life matters, this ruling was perhaps most significant in that it highlighted the Court’s contrasting preparedness to defend individual rights and the legitimate process of plebiscite driven (PAS) policy. Certainly a like conclusion could also be drawn about US Federal authority’s 2005 intervention in order to preserve the life of PVS patient Terri Schiavo. Once again, the Courts came out in support of the patient’s (alleged) wish and that of her (former husband)


guardian to remove her feeding tube which had—for well over a decade—sustained Schiavo’s arguably futile existence.\textsuperscript{163}

\textbf{The Australian End of Life Debate: 1950s–2007}

Although there is a limited array of historical material to be found on the mid-20\textsuperscript{th} Century Australian euthanasia debate, of particular note is the \textit{Medical Journal of Australia}’s Dr. Ronald Winton’s (1950) claim that “there are many cases when euthanasia is practiced” and that \textit{despite} prevailing edicts depicting mercy killing as a violation of “Divine and human law”.\textsuperscript{164} In light of this concession, Sydney University Professor A.K. Stout challenged mainstream medical thought by expressing in principle support for AVE, having reasoned that “It is wrong to compel a person with an incurable, intolerable disease to continue living”, only to endure “a painful and lingering death”.\textsuperscript{165} Statements in favour of a ‘good’ death were, nevertheless, refuted by the Catholic Church on grounds that euthanasia was an irresponsible and emotively driven undertaking.\textsuperscript{166} In contrast to the uncompromising message of Catholic theologians, the unaffiliated Independent Church’s Reverend Lyall Dixon counter-argued that there was \textit{no} scriptural basis to oppose euthanasia and most particularly, “when it becomes obvious that the body has run its course”.\textsuperscript{167} Within a decade of Dixon’s statement other Protestant theologians, such as


\textsuperscript{164} “Euthanasia ‘Murder’ says Doctor”, \textit{Sydney Morning Herald}, 16 November 1950, p.3

\textsuperscript{165} “Euthanasia Debated at University”, \textit{Sydney Morning Herald}, 18 April 1951, p.4

\textsuperscript{166} “Apostolic Delegate Warns Doctors”, \textit{Sydney Morning Herald}, 4 May 1959, p.5

\textsuperscript{167} “Minister Backs Mercy Killings”, \textit{Sydney Morning Herald}, 21 November 1960, p.17
Anglican Reverend (Prof.) Welford, contended that human life was not always inherently valuable, nor was it necessarily improper to provide a ‘good’ euthanasia death.\textsuperscript{168} Welford’s comments evoked an expression of sympathy from the Convenor of the Presbyterian Church, the Reverend Arthur North, who described these remarks as “timely”. Indeed, North echoed the sentiments of clerical predecessors, such as Donne and Burton, insisting that human beings had a “duty to use intelligent control over physical nature rather than submit to its blind workings”.\textsuperscript{169}

The suicide of high profile euthanasia advocate Dr. Leslie Jarvis in 1976 epitomised the predicament faced by suffering individuals, as the self described “cardiac cripple” had left a note stating—“I cannot tolerate the thought of being a burden on my loved ones and on society….I have, therefore, decided to depart from this life by the comfortable and perpetual sleep of honourable euthanasia”.\textsuperscript{170} The idea that life without quality or beyond reason could be legitimately forfeited was again endorsed that same year, with the New South Wales Government approving of the cessation of extraordinary life-support technology upon an irreversibly brain damaged 16 year old boy. Whilst keen to point out that this undertaking was \textit{not} akin to the practice of \textit{active euthanasia}, the Minister for Health conceded that “people should be allowed to live and die with dignity”.\textsuperscript{171} In 1978, the Nobel-prize winning scientist Sir Macfarlane Burnet concurred that it was “logically absurd to continue to believe that life must be conserved at any cost”. In lieu of an


\textsuperscript{169} “Mercy Killing Views Opposed”, \textit{Sydney Morning Herald}, 8 June 1970, p.5

\textsuperscript{170} “Euthanasia Doctor takes own Life”, \textit{Sydney Morning Herald}, 24 February 1976, p.3

\textsuperscript{171} “Decision to let Boy Die Right – Minister”, \textit{Sydney Morning Herald}, 26 November 1976, p.4
“absolute and unchangeable” sanctity of life credo, Burnet maintained that there should be a “slow and tentative” relaxation of laws against beneficent killing, in order to minimise unnecessary “pain, misery and indignity”. The academic community continued to feature prominently in the end of life debate well into the 1980s, as Professor Harry Lander commented in 1984 that the (economically) unsustainable practice of prolonging futile life demanded that legislators take immediate steps to change the law on euthanasia. While Lander’s utilitarian argument was controversial, a 1988 Monash University survey of 869 of the nation’s doctors confirmed that some 62 per cent of respondents approved of “ending the lives of patients who no longer want[ed] to live”.

Despite the fact that opinion polls collated in the 1990s indicated that three quarters of citizens supported last resort AVE, this practice remained outlawed in all Australian States. The Northern Territory ultimately became the first and only locale in the country which was prepared to accede to popular opinion, having implemented the groundbreaking Rights of the Terminally Ill Act – ROTTIA (1995). This world-first legislation enabled terminally ill individuals to avail themselves of physician-assisted suicide or active voluntary euthanasia under the strict proviso that applications could only be made by rational, non-clinically depressed adults who were encountering intolerably severe pain.

175 Cosic, op.cit., p.162
176 A detailed account of the ROTTIA and its passage through the Northern Territory Parliament is provided in Chapter Eight.
and suffering. Following the deaths of four patients, the Liberal–National Federal Government (backed by more conservative elements within the opposition Labor Party) dismissed the protests of the Territory Administration by invoking its veto power in order to disallow the *ROTTIA* in March 1997. Critics immediately counter-claimed that the duty of democratic (Federal) representatives to uphold the wishes of the citizen majority had, in effect, been trounced in favour of ideologically driven sanctity of life and slippery slope assumptions.

Exit International founder and leading pro-euthanasia lobbyist Dr. Philip Nitschke refused to abandon the reform process, having asserted in 1999 that even terminally ill children from 12 years and up should have access to AVE procedures. Nitschke reasoned that “If you believe a peaceful death is everyone’s right, then you can’t somehow or another exclude that from children.” This controversial advocate again demonstrated the extent of his pro-choice convictions following his expression of support for the Nembutal induced (May 2002) suicide of 69 year old Exit member, Nancy Crick. Nitschke was later subject to strong criticism, however, after a post-mortem revealed that Crick had not, in fact, been suffering from terminal cancer. Although Nitschke claimed to be “shocked” by the news that no trace of cancer was found in Crick’s body, it was arguably “of little importance”

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179 The debate over the right of the State to circumvent the popular will (in the service of the greater good) will be revisited in Chapter’s Seven, Eight, and Nine.

180 “Euthanasia backed for young”, *Daily Telegraph*, 12 August 1999, p.21
} Nitschke further maintained that “None of the palliative [care] measures initiated by Nancy’s bevy of treating doctors in those last months gave her any significant relief.”\footnote{Nitschke & Stewart, op.cit., pp.257–258} Crick’s son Daryle provided a corroborative account, stating that his mother had been in “terrible pain” which Nitschke later ascribed to the build-up of scar tissue from previous cancer surgeries.\footnote{G Stolz, “Supporters Defend Suicide Help”, \textit{Courier Mail (QLD)}, 9 June 2004, p.3} After two years of official investigation into the events surrounding Crick’s death, the Queensland Police Department declined to lay charges upon any of the 21 persons who had witnessed the patient’s passing.\footnote{D Macfarlane & S Tedmanson, “Charges unlikely over Crick’s Assisted Suicide”, \textit{Australian}, 12 June 2004, p.3} Police Commissioner Bob Atkinson announced that there was “insufficient evidence to support any charge against any person” in relation to Crick’s suicide, because merely “being present when someone takes their life does not in itself constitute an offence”.\footnote{Nitschke & Stewart, op.cit., p.225} The Federal Government has since moved to minimise the opportunity for suicide advocacy by banning the electronic (fax, email, or internet) transmission or publication of end of life procedures in accordance with the \textit{Suicide Material Offences Act (2005)}.\footnote{Additional discussion on the \textit{Suicide Material Offences Act} is provided in Chapter Seven.}

Following the Crick incident, Philip Nitschke undertook a series of Exit workshops in which the construction and application of the physician’s self-styled carbon-monoxide generating \textit{Co-Genie} suicide machine, was demonstrated. Mindful of a desire to make this
technology readily accessible, Nitschke advised that a replica *Co-Genie* could be constructed from supermarket and hardware store items from as little as $52–00.\(^\text{187}\) Despite criticism from the likes of Margaret Tighe of Right to Life Australia and former Western Australian AMA President Dr. Simon Towler that Nitschke was exploiting “fragile and vulnerable” members of the community, the workshops proceeded uninhibited.\(^\text{188}\) A police spokesperson later clarified the law’s position on the matter by advising these and other complainants that the “Setting up [of] a workshop on suicide is not a crime”.\(^\text{189}\) Since this time, Nitschke has reiterated that an alternate lethal barbiturate pill should be developed to provide people with the option of an ultra-convenient “peaceful, reliable death”.\(^\text{190}\) Indeed, Nitschke maintains that the envisaged “Peaceful Pill has a big future…not only for the seriously ill but for all rational, elderly members of our community”.\(^\text{191}\) This controversial practitioner insists that “If a Peaceful Pill was widely available, nursing homes would only be inhabited by people who were happy about still being alive”.\(^\text{192}\) Unlike last resort active euthanasia and physician-assisted suicide, the alleged benefit of the proposed lethal tablet is that it could be ingested by a person *before* they had forfeited their dignity or had become totally dependent upon others.\(^\text{193}\) This ultra-individualistic approach to end of life


\(^{\text{188}}\) Nitschke & Stewart, op.cit., p.292. See further T Harris, “Nitschke’s Death Workshops go on”, *Australian*, 20 May 2003, p.4

\(^{\text{189}}\) Harris, op.cit., p.4

\(^{\text{190}}\) M Zlotkowski, “Dr. Death promotes Final Pill”, *Cairns Post*, 19 May 2005, p.7

\(^{\text{191}}\) Nitschke & Stewart, op.cit., p.320

\(^{\text{192}}\) ibid., p.322

\(^{\text{193}}\) The issue of end of life autonomy is addressed in Chapter Four.
decision making has, nevertheless, been rightfully criticised because it offers no fail-safe auditing process aimed at discouraging the termination of life without just cause.

Whilst assisted suicide remains as an offence in Australia, in recent times the Judiciary has lent a sympathetic ear to those accused of aiding suffering individuals to end their life. For instance, in 2003 Victorian resident Alexander Gamble Maxwell was awarded an 18 month suspended gaol sentence after having plead guilty to “aiding or abetting” his cancer-ridden wife’s suicide. During sentencing, Justice John Coldrey indicated to the accused that the “unique circumstances of this tragic case” meant that “thoughtful members of the community…would regard your immediate imprisonment” as unnecessary. 194 A 12 month suspended gaol sentence was handed down the following year to John Stuart Godfrey, after being found guilty of having assisted his sick and intolerably distressed 88 year old mother to die. The Tasmanian Supreme Court acknowledged that Godfrey’s action had been “motivated solely by compassion and love”. Indeed, Justice Peter Underwood emphasised that current legislation appeared to unduly discriminate against people who wanted to end their lives, but were physically incapable of doing so. 195 The New South Wales Supreme Court has more recently handed out good behaviour bonds to Margaret and Raymond Sutton in the wake of their guilty plea on a charge of manslaughter. The April 2007 ruling took into account that the killing of the Sutton’s intellectually disabled (28 year old) son Matthew had been entirely motivated by a desire to end his “pain and suffering”. In addition to the challenges that Sutton already faced, the spectre of a pending surgical


195 A Darby, “Son who helped his Mother Die was driven by Love”, Sydney Morning Herald, 27 May 2004, p.10
procedure that would have denied him his sense of taste and hearing would only have further undermined his already limited quality of life. In passing judgment, Justice Barr acknowledged that the Suttons’ action was born out of genuine compassion for their son.\textsuperscript{196} Traditional assumptions about the State having an obligation to uphold the principle that the intentional termination of innocent life is never permissible were, therefore, arguably dispelled by these reasoned judicial rulings.

\textbf{End of life Choice in the Netherlands, Belgium, and Switzerland}

Despite some progress, it is clear that the Dutch are well ahead of their Australian counterparts in end of life affairs having permitted physicians to go unpunished for beneficent acts of PAS or AVE in the wake of a practitioner’s (1973) suspended sentence for the morphine induced termination of his suffering mother’s life. In a subsequent landmark trial, the Dutch Supreme Court overturned the 1984 conviction of a physician for having killed a patient who had revealed a desire for euthanasia in their will. The sympathetic Judiciary later ruled that the dilemma between preserving life and alleviating the patient’s distress had been conscientiously resolved by the accused.\textsuperscript{197} Dutch physicians were, thus, made aware that they could avoid prosecution by demonstrating that their patient was competent, had made multiple requests to die, and that these petitions were in response to an incurable, intolerable, terminal phase medical condition.\textsuperscript{198} The Netherlands authorities have, subsequently, moved to provide full legal immunity for physicians to


\textsuperscript{197} T Sutherland, “Dutch first with Legal Euthanasia”, \textit{Australian}, 12 April 2001, p.10

carry out PAS and AVE strictly in accordance with the guidelines set out in *The Termination of Life on Request and Assistance with Suicide Act (2002)*. This particular Act formerly stipulates that a patient’s resolution to die must be freely made, that their condition is incurable and causing intolerable suffering, and that there are no other satisfactory alternatives to that of an induced death.\textsuperscript{199} The legislation permits adults and “minors aged between 12 and 15” to undertake euthanasia with the consent of their parents, while those aged 16 and 17 can effectively make their own choice on the matter, albeit in consultation with their parents.\textsuperscript{200} Whilst it is maintained that active euthanasia remains as an offence, the Dutch authorities have explained that “the Criminal Code…exempt[s] doctors from criminal liability if they report their actions and show that they have satisfied the due care criteria formulated in the Act”.\textsuperscript{201} Indeed, it is emphasised that “The main aim of Dutch policy on euthanasia is to guarantee that every step toward the termination of life is taken openly, reviewed in a consistent manner, and surrounded by meticulous care.”\textsuperscript{202}


\textsuperscript{202} Ministry of Health, Welfare and Sport, *Dutch Policy on Voluntary Euthanasia*. 
experts) which is then required to assess if the Act’s guidelines have been properly adhered to.\textsuperscript{203} If there is reason to believe that a physician has failed to meet established criteria, the Committee must then advise the Board of Procurators-General which is empowered to forward the case to the Public Prosecution Service for possible legal action.\textsuperscript{204}

In the wake of the Netherlands’ legislation, Belgium has since decriminalised active voluntary euthanasia in 2002. This popularly supported reform provides physicians with immunity from prosecution in undertaking AVE in response to an incurable and unbearably painful terminal condition.\textsuperscript{205} The physician concerned must agree that the rational adult or emancipated minor’s suffering is indeed considerable, confirm this assessment with a fellow practitioner, and offer alternate palliative care measures. If last resort euthanasia is carried out, the physician is required to register the death with the nation’s Federal Control and Evaluation Committee.\textsuperscript{206} In contrast, Switzerland permits the singular option of PAS as a humane last resort alternative for intolerably afflicted, terminally ill patients.\textsuperscript{207} Under Swiss law, practitioners risk prosecution only if legal guidelines are violated such as in the case where a patient is lured into PAS in order to

\textsuperscript{203} Ministry of Health, Welfare and Sport, \textit{The Netherlands New Rules}.


\textsuperscript{205} R Watson, “News Roundup – Belgium gives Terminally Ill People the Right to Die”, \textit{British Medical Journal}, Vol.323, No.7320, 3 November 2001, p.1024


placate the wishes of other parties. Unlike the Netherlands and Belgium, Switzerland permits foreigners (labelled in certain quarters as “death tourists”) to enter the country in order to take advantage of this assisted suicide law. In spite of these divergences in eligibility, it is apparent that Switzerland, Belgium, and the Netherlands have effectively come the full circle in resurrecting the Ancient European practice of a self appointed ‘good’ death.

**Conclusion**

Throughout this historical survey, emphasis has been placed upon the fact that intolerable circumstances and reasoned intent provide a powerful argument in favour of end of life choice. This discussion has revealed that a similar policy was endorsed in the Ancient Greek and Roman worlds where, notwithstanding duties owed to the Gods or the State, the authorities made provision for suicide or euthanasia in response to irremediable suffering and/or futility. It was later asserted that these views were at a variance with the more restrained (deontological) sanctity of life assumptions of the Hippocratic medical fraternity and latter day Christian theologians. While the pro-life religious doctrine of Augustine, Aquinas, and Luther ultimately perpetuated the notion of end of life restraint for much of Christianised Western history, it was pointed out that renewed interest in Ancient Greek and Roman thought along with the dawning of an ‘enlightened’ academic age inspired a number of scholars (such as Bacon, Donne, and Hume) to defend rational end of life choice on merciful and personal liberty grounds. It was later acknowledged that while

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209 K Wheatley, “Woman, 93, in Mercy Death”, *Sunday Mail (South Australia)*, 2 July 2006, p.1
Immanuel Kant rejected this rationalisation of suicide and active euthanasia in deference to an arguably more compelling secular sanctity of life principle, other secular thinkers such as Nietzsche and Darwin advocated a more permissive (utilitarian) response to human frailty and suffering.\(^{210}\) Despite the fact that quality of life considerations were implicitly emphasised as preceding unduly rigid vitalist assumptions, those who favoured legalised AVE tended to remain on the fringes of orthodox medical and clerical thought well into the 20\(^{th}\) Century. While those who supported prohibition were often driven by traditional moral principles, pragmatic considerations also informed anti-reform arguments. Indeed, the discussion on Nazi Germany’s unscrupulous T4 ‘euthanasia’ programme lent credibility to related claims that State sanctioned ‘mercy killing’ could conceivably open the floodgates to all manner of active euthanasia abuses.\(^{211}\)

Despite the efforts of concerned theologians, the medical profession, and conservative politicians to forestall an AVE reform inspired slippery slope, it was pointed out that the Judiciary exhibited a preparedness to deal sympathetically with those involved in genuinely compassion driven active and passive euthanasia. This was particularly evident in the cases of Karen Ann Quinlan and Nancy Cruzan, as the Courts’ ordered that life sustaining medical technology be removed in accordance with the patient’s (alleged) prior wishes not to be sustained in a futile condition. It was clear that the right to waive extraordinary life sustaining measures would not, however, satisfy all patients as the more recent Jack Kevorkian affair provided a timely reminder that for some people there is no

\(^{210}\) Utilitarian arguments are investigated and critiqued in Chapter Five.

\(^{211}\) Please note that Chapter Three provides an account of the slippery slope theory that acknowledges the risks of legalised AVE without necessarily accepting the inevitability of a slide into wholesale active euthanasia abuses.
other acceptable alternative than to opt for an active euthanasia termination. Despite that fact, US and Australian federal interventions aimed at stifling popularly supported choice in dying legislation in Oregon and the Northern Territory highlighted the tension that continues to exist between supporters of enhanced individual end of life rights and more traditional sanctity of life and collective good advocates. It was, nevertheless, acknowledged that activists, such as Philip Nitschke, have attempted to satisfy the public demand for choice in dying by offering potentially problematic (unsupervised) suicide alternatives. While it was conceded that there are also difficulties involved in overcoming legitimate (post-AVE) slippery slope concerns, this risk failed to discourage assisted suicide and AVE legislative reforms in the Netherlands, Belgium, and Switzerland. Although the ensuing (European) legislation has not always allayed concerns about the decriminalisation or legalisation of AVE (or PAS), the next chapter will investigate whether other Western nations (such as the US or Australia) can continue to justify their opposition to right to die legislation on grounds of slippery slope speculation and/or on the basis of a traditional sanctity of life moral principle.

212 The Death with Dignity Act and the Rights of the Terminally Ill Act are considered in further detail in Chapter’s Six through Nine.
3 CONTEMPORARY EUTHANASIA ISSUES

Introduction

Following on from the previous chapter’s exploration of historical attitudes toward choice in dying, this chapter will focus upon the rival ethical arguments in the contemporary euthanasia debate as portrayed by analysts including Nigel Biggar, James Rachels, Peter Singer, Helga Kuhse, Marvin Kohl, John Keown, and Margaret Somerville. In particular, this discussion will demonstrate that the dispute over end of life choice is primarily driven by those who prioritise quality of life considerations versus that of others who maintain that the risk of falling prey to slippery slope abuses is too great.¹ Although it will be argued here that AVE is a necessary last resort option in cases of intolerable terminal suffering, the tendency of reform advocates to downplay slippery slope concerns will, nevertheless, be challenged on grounds that State sanctioned euthanasia could have potentially significant welfare ramifications for all vulnerable patients. In addition to the claim that a slippery slope risk assessment is an indispensable policy consideration, this discussion will also explore the dying experience and pain management dilemmas in the knowledge that these issues will have a bearing on subsequent chapters’ political theory appraisal of the euthanasia reform debate.

The Sanctity of Life and Quality of Life Debate

Despite the fact that the Human Rights Declaration, the European Convention, and the International Covenant on Civil and Political Rights enshrine the notion that life is a value upon which all other ends (including individual rights) are reliant, contentions have arisen over claims that life is uniquely valuable irrespective of any external standard or condition.² Although this intrinsic good (sanctity of life) ideal is central to the West’s moral (Judeo-Christian) tradition, right to die advocates maintain that the value of life is not a given but rather, is commensurate with its quality.³ Indeed, it has been argued that the most important thing is not that an individual is living but whether their existence provides an opportunity to experience the ‘good life’.⁴ In particular, the capacity for a “rational, purposeful” existence with “hopes, ambitions, preferences…purposes” and “ideals” are, according to Helga Kuhse, integral factors in ensuring that life is “a means to a further end”.⁵ This quality of life argument has failed to convince more conservative elements who


⁵ Kuhse, op.cit., p.14
insist that the sanctity of (innocent) life is an indispensable component of the good society.\(^6\) Others, such as Peter Singer, have alleged that this assertion is based upon “fictions” and ethically unsustainable “outmoded views”.\(^7\) In fact, James Rachels maintains that the traditional sanctity of life principle is “contrary to reason” because it “places too much value on human life” [emphasis added].\(^8\)

In the interests of minimising needless suffering, it has been suggested by Singer that the traditional sanctity of life ethos must be relinquished in favour of a “more compassionate” and “responsive” end of life code.\(^9\) At the heart of this recommendation is a desire to temper—rather than eliminate—respect for life by accommodating indispensable quality of life considerations.\(^10\) While it has been argued that it is possible to determine if the quality of a patient’s existence is negligible or non-existent, it is clearly preferable for competent patients to draw their own conclusions as third party quality of life assessments may misinterpret an individual’s actual level of contentment.\(^11\) Obviously, the temptation to project external quality of life assumptions onto others can lead to mistaken assumptions, as even the most sorely afflicted of individuals may cherish their sub-standard existence.\(^12\)

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\(^7\) P Singer, Writings on an Ethical Life, Fourth Estate, London, 2000, p.324

\(^8\) Rachels, The End of Life, p.2 & p.24

\(^9\) Singer, Writings on an Ethical Life, p.168


Moreover, there is evidence to suggest that patients with a poor quality of life prognosis sometimes go on to experience a more fulfilled life than could have reasonably been anticipated.\(^\text{13}\)

**The Dignity Argument**

Although it is argued here that non-voluntary euthanasia and involuntary euthanasia are risk laden and presumptuous practices, it is reasonable to suggest that the right to escape a demoralising and futile terminal existence via active voluntary euthanasia ultimately honours the right principle of life as patient initiated choice and dignity are mutually reinforcing ideals.\(^\text{14}\) Critics have counter-argued, however, that an honourable death need not necessitate an autonomous demise as even the most traumatic dying process provides an opportunity for expressions of courage and resolve.\(^\text{15}\) Right to die advocates have also been criticised for portraying euthanasia in an unduly idealistic light as any process of dissolution purportedly entails some measure of indignity.\(^\text{16}\) Leading reform advocate Derek Humphry has conceded as much, having observed that even a “well planned death” can be “slow, noisy, upsetting, and unpleasant to witness”.\(^\text{17}\) While this claim is difficult to


refute, it cannot be overlooked that for some intolerably afflicted patients the need to regulate the circumstances of their death precedes all other considerations. This is not to suggest that AVE is suitable for everyone, only recognition of the fact that what is deemed an acceptable terminal burden for one patient, may be overwhelming to another.

The Extraordinary Measures Issue

John Keown maintains that AVE reform opponents are not without discretion as they generally accept that life is not the “highest good” upon which “all…other basic goods must be sacrificed in order to ensure its preservation”. 18 The Catholic Church’s Declaration on Euthanasia is an exemplary case in point, as it acknowledges that any medical undertaking which promises only to “secure a precarious and burdensome prolongation of life” is to be avoided. 19 This option to cease or refuse extraordinary medical measures including surgery, life support apparatus, or drugs can become a source of conflict, however, and most particularly when a treating physician views a given procedure as a routine rather than extraordinary intervention. 20 Certainly a physician may be influenced to take this stance in the knowledge that medical competence in an age of technological sophistication is increasingly defined by their capacity to actively utilise these innovative yet often invasive resources. 21 The temptation to over-treat patients has

18 Keown, Euthanasia, Ethics and Public Policy, p.41


been further exacerbated by a culture of rapid medical advances, as yesterday’s extraordinary measure is relegated into today’s routine practice.22

The likelihood of a practitioner bringing to bear extraordinary life saving resources is further exacerbated amongst those who tend to view their patients as a medical challenge rather than as persons.23 Timothy E. Quill claims that Western medical training has inadvertently promoted this rationale, alleging that “the prolongation of life is given a much higher value than the lessening of human suffering”, and that, “even in the care of the dying”.24 As a result, life preserving medical interventions on ethical (i.e. sanctity of life) or legal grounds (i.e. the threat of being sued for medical negligence) have ensured that some terminal patients have had their suffering unduly prolonged.25 While Philippa Foot maintains that the opportunity for the patient to ensure that their “fatal sequence” is “allowed to take its course” provides a welcome alternative, Helga Kuhse insists that a decision to remove or exclude life preserving treatment ought to be acknowledged as the “most significant and morally relevant” cause of death for some patients.26 The idea that the withdrawal of a dying patient’s feeding tube, for example, is fundamentally different from providing a life ending injection is potentially difficult to sustain, as the patient’s

22 A Shaw, “Dilemmas of ‘Informed Consent’ in Children”, in, Horan & Mall (eds.), op.cit., p.88


24 TE Quill, Death and Dignity, WW Norton and Co., New York, 1994, p.49


‘premature’ demise is plainly foreseen.27 One might conclude, therefore, that a State which permits the withdrawal or omission of life saving extraordinary medical measures in order that ‘nature’ might take its inevitable course, yet denies the arguably more compassionate option of a swift AVE death, is perpetuating a double standard.

**Pain Management Dilemmas**

While the exclusion of futile or burdensome extraordinary medical measures is motivated by quality of life considerations, calls for an AVE option in the face of intolerable terminal pain and suffering are clearly an extension of this same principle. The *Oxford Textbook of Palliative Medicine*’s admission that “certain types of pain are invariably difficult to manage and a small percentage may be intractable to all treatment” has, however, been tempered by palliative care practitioner Professor Peter Ravenscroft who insists that the level of distress can generally be brought to a point that the patient “can live with” [emphasis added].28 In pursuit of that end, practitioners have long relied upon the potent pain killing properties of morphine. Whilst this potentially addictive analgesic may cause vomiting, constipation, and induce a stupor like state, its most important property is that recipients do not develop a resistance to its ameliorating impact upon severe pain.29

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cases where patients suffer a particularly adverse reaction to morphine, symptoms can often be alleviated with other medications or else an alternate pain-killer may be adopted.30 These contingency options should not, however, divert attention from the fact that around 5 per cent of terminal patients still experience unresolved pain despite targeted medical intervention.31 As a practicing physician, Charles McKhann has confirmed that some patients “suffer severely at the end of life” while fellow practitioner Timothy E. Quill agrees that patients can still experience “anguishing deaths” in spite of the “heroic efforts” of “skilled physicians, nurses, and family members”.32 For instance, Quill has pointed to the “excruciating” ordeal of patients afflicted with respiratory problems who, he says, can experience “a panicked, suffocating struggle just prior to death”.33 Indeed, one patient observed that their experience with terminal suffering was so intense, that they felt as though they were becoming “less of a human being”.34 The implication that terminal distress is, as James Rachels’s describes, ultimately “beyond the comprehension of those who have not actually experienced it” undoubtedly inspires questions about the anti-AVE lobby’s commitment to beneficent treatment and the individual good [emphasis added].35


30 Cundiff, op.cit., pp.120–121


32 C McKhann, A Time to Die – The Place for Physician Assistance, Yale University, London, 1999, p.79. See further Quill, op.cit., p.23


The anti-AVE lobby has endeavoured to defend their position by arguing that a culture of unmanaged pain is largely avoidable, having alleged that the medical profession often fails to ensure *attainable relief*.\(^{36}\) Indeed, analysts including Dr. Sydney H. Wanzer *et al* have confirmed that concerns raised about deficient pain relief practices are “to a large extent…justified”.\(^{37}\) This may be inspired by a variety of factors including poor doctor–patient communication, practitioner desensitisation to suffering and/or sub-standard pain management facilities and training.\(^{38}\) In the latter case, Wanzer *et al* report that “adequate narcotic management seems to be *an unfamiliar area to many physicians*” [emphasis added].\(^{39}\) US medical authorities have conceded that this is an ongoing problem, as only a minority of physicians practice ‘state of the art’ pain management techniques.\(^{40}\) The President of the Australian Association of Hospice and Palliative Care, Dr. Michael Smith, has similarly observed that “the level of knowledge and experience required to effectively manage the symptoms of people in such dire circumstances that they may be seeking euthanasia, is still not achieved by enough practitioners”.\(^{41}\)

\(^{36}\) Somerville, *Death Talk*, p.201


\(^{38}\) Somerville, *Death Talk*, p.201

\(^{39}\) Wanzer *et al*, op.cit., p.288


\(^{41}\) Senate Legal and Constitutional Legislation Committee, op.cit., p.74 [6:77]
Concerns about addiction and/or legal liability have undoubtedly contributed to a culture where some physicians are reluctant to provide adequate pain relief. Indeed, Timothy E. Quill maintains that physicians are “repeatedly warned” in medical school about “the dangers of over-sedation and addiction that can accompany the use of narcotic pain relievers”. The tendency to ration pain relief substances is, however, contrary to beneficent medical practice as Wanzer et al have argued that “Narcotics or other pain medications should be given in whatever dose and by whatever route is necessary for relief”. This pro-active approach to patient care is crucial if only because unresolved pain can rapidly deplete an already stressed individual’s resistance to life-threatening infection. Equally importantly, once patients become aware that their pain management needs may not be met there is a tendency for a psychologically inspired intensification of the pain sensation. Under these sorts of circumstances, it is conceivable that a plea for active euthanasia might actually mask a failure on the part of a presiding physician to ensure adequate pain relief. While it bears reiteration that a residual 5 per cent of patients will still experience intolerable suffering despite intervention, it is equally apparent that euthanasia requests can only be kept to a minimum if more extensive training in palliative

42 Somerville, Death Talk, p.201
43 Quill, op.cit., p.79
44 Wanzer et al, op.cit., p.287
45 Cundiff, op.cit., pp.118–119
care is provided and physicians are mindful of their obligation to ensure that attainable pain relief requirements are met.

**The Doctrine of Double Effect**

In some instances, medical practitioners respond to the most severe forms of (end of life) distress by placing patients in an unconscious (morphine induced) state. While it is conceded that *terminal sedation* does not eliminate a patient’s pain it is deemed as a preferable approach to active euthanasia by Margaret Somerville because it avoids the allegedly “harmful impact of euthanasia on societal values and symbols”. It would defy credibility however to assume that members of the public are unaware that this favoured terminal sedation process can degenerate into a farce, as sufficiently large dosages of morphine may *induce* a premature death via respiratory suppression. This so called *doctrine of double effect* is not uncommon, as Wanzer *et al* have confirmed that it is “morally correct to increase the dose of narcotics to whatever dose is needed” to palliate terminal suffering—even though it could conceivably lead to an unintended premature death. In order to minimise accusations of an intentional ‘double effect’ demise, practitioners are traditionally advised to provide the lowest medication dosage required to ensure adequate pain relief, with higher dosages to be prescribed only if symptom relief is not achieved. As an added safeguard, it is recommended that any decision on medication

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48 Barbato, op.cit., p.55

49 *ibid.*, & Somerville, *Death Talk*, p.162

50 South Australian Voluntary Euthanasia Society (SAVES), Inc., *The Right to Choose*, p.26

51 Wanzer *et al*, op.cit., p.287
should appear ‘reasonable’ to fellow practitioners and nursing staff. The fact that these provisions have not always stopped terminal patients from succumbing to a ‘double effect’ demise has, nevertheless, inspired speculation that pain management techniques are indeed being utilised in order to evade responsibility for a clearly anticipated (covert euthanasia) death. Dr. Philip Nitschke is convinced that this is so, having likened this pain management process as something of a “game” with the physician communicating in code to the family that the patient is being made “comfortable” in their final stages.

Laying the blame of a patient’s morphine hastened death on their “underlying condition” is, says Margaret Otlowski, ultimately little more than “legal sophistry”. In spite of these allegations, Margaret Somerville insists that there remains a “Profound ethical and legal difference” between implementing pain management measures that could inadvertently shorten life, and that of intentionally killing a patient. Certainly this distinction is well recognised in Western medical tradition, for while the commitment to alleviate distress is acknowledged as standard beneficent practice, the intentional termination of a patient’s life (via active euthanasia) has typically been construed as a ‘harmful’ act. This interpretation remains difficult to defend, however, given that beneficence implies a commitment to act

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54 Nitschke & Stewart, op.cit., pp.152–153

55 M Otlowski, *Active Voluntary Euthanasia – A Timely Reappraisal*, University of Tasmania Law School, Hobart, 1992, p.23


57 Cosic, op.cit., pp.117–119
in the best interests of the patient whose incurable and intolerable terminal pain could be resolved by acceding to a last resort AVE request. While it is conceded that a patient’s suffering can also be alleviated by a double effect remedy, Peter Singer has posed the obvious question “why any dying patient would prefer to be unconscious for a few days, and then die, rather than die straight away”.

The Issue of Depression

The President of the Australian and New Zealand Society for Palliative Medicine, Professor Peter Ravenscroft, has attempted to discredit calls for an AVE alternative, having asserted that “existential problems” including a “loss of self-worth”, feelings of “fear, guilt, anger, resentment and anxiety” can inspire arguably unwarranted euthanasia requests. In light of this legitimate concern, it is necessary to distinguish between the alleviation of physical and psychological distress, as Daniel Callahan has affirmed that “the relief of pain…is not identical to the relief of suffering”. Certainly this can present physicians with a particularly difficult challenge as deep-seated psychological torment is commonly described in medical circles as “opiod irrelevant pain”. This is, indeed, a significant factor in end of life care as the American Journal of Psychiatry has confirmed that the overwhelming majority of patients who seek a euthanasia termination are “suffering from a treatable mental illness” and “most commonly a depressive condition”


59 Senate Legal and Constitutional Legislation Committee, op.cit., p.75 [6.83]

60 D Callahan, “Care of the Elderly Dying”, in, Walter & Shannon (eds.), op.cit., p.249

61 Hanks, op.cit., p.257
Apart from this latter disorder’s more obvious manifestations of gloominess and melancholy, depression can leave sufferers with an inability to find pleasure in relationships, a loss of appetite, fatigue, sleep disturbances, agitation, and recurring thoughts of death. The depressive state may also lower a patient’s threshold to physical pain, making the challenge of palliation all the more difficult. While the provision of targeted treatment and a supportive social network has been credited with reversing as many as 85 per cent of euthanasia requests, one could argue that the remainder are either incapable of rational thought and in need of ongoing paternal oversight or alternatively, are justified in their appeal for last resort AVE. Questions have, nevertheless, been raised as to whether fallible practitioners can ever be sure that a dying patient who requests a termination is not suffering from a perception distorting depressive condition. It is argued here that this potentiality should not discourage policy makers from implementing AVE reform, as reason dictates that the duty of care toward terminal patients effectively ends at the point where no further precautionary measures (i.e. comprehensive physiological and psychological assessments) appear needful.

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65 Somerville, Death Talk, p.146

The Doctor–Patient Relationship

Despite arguments in support of strictly regulated AVE, the Hippocratic Oath’s sanction against the killing of patients and the contemporary Declaration of Geneva’s call for physicians to exhibit “the utmost respect for human life” has prompted counter-claims that the legalisation of euthanasia would have a profoundly detrimental impact upon the doctor–patient relationship.\(^67\) In fact, the American Medical Association has declared that active euthanasia is “fundamentally incompatible with the physician’s role as a healer”, while the Australian Medical Association insists that “doctors should not be involved in interventions that have as their primary goal the ending of a person’s life”.\(^68\) Whilst these statements are partly motivated by a desire to ensure that patient trust is preserved, it could be argued that the legalisation of strictly regulated voluntary euthanasia need not undermine the vast majority of patients’ relationship with their physician.\(^69\) Although one recent (US) study indicated that 20 per cent of respondents felt that their level of trust in their physician would decline in a post-legalised AVE climate, this potentially misplaced loss of confidence is conceivably less significant than the threat of unresolved intolerable terminal pain.\(^70\) Anti-AVE lobbyists have, nevertheless, persisted with claims that State sanctioned euthanasia could ultimately desensitise practitioners to the point where they


\(^{69}\) MD Bayles, “Euthanasia and the Quality of Life”, in, Walter & Shannon (eds.), op.cit., p.273

behave in a callous or unethical fashion.\textsuperscript{71} It has been suggested that this problem is likely to be further exacerbated under circumstances where a physician is tempted to relieve themselves and/or others of a particularly difficult patient.\textsuperscript{72} Whilst not endorsing this rationale, Dr. William W. Weddington, Jr. expressly acknowledged in the \textit{Journal of the American Medical Association} this potentiality, having stated that:

\begin{quote}
Critically ill, probably terminal patients are often tiring, unsatisfying and difficult to care for….How tempting it is to hear a request to speed up the dying under the guise of relieving the patient’s ‘agony’ when indeed others’ suffering may well be the issue.\textsuperscript{73}
\end{quote}

Although fellow practitioners would likely expose anyone within their ranks who imposed this type of clandestine active euthanasia, John Keown has rightly cautioned that there is a tendency on the part of some doctors to “overlook their colleagues’ unprofessional behaviour”.\textsuperscript{74}

\textbf{The Slippery Slope Debate}

Concerns about physicians violating their duty of care in a post-reform climate are indicative of an underlying scepticism that once the sanctity of life principle is breached, this exception will invariably lead to ever more extensive steps up to and including non-

\textsuperscript{\textit{71}} Somerville, \textit{Death Talk}, p.81. See further Senate Legal and Constitutional Legislation Committee, op.cit., p.72 [6:68]


\textsuperscript{\textit{74}} Keown, \textit{Euthanasia, Ethics and Public Policy}, p.75
voluntary and even involuntary euthanasia. For example, Germain Grisez and Joseph M. Boyle insist that *non-voluntary active euthanasia* (NVAE) will follow in the wake of AVE legislation simply because it would be an “irrational and arbitrary limitation” to deny ‘beneficent’ killing to those individuals who are construed as being “better off dead”.

Given that some physicians could also be enticed to undertake *involuntary active euthanasia* (IAE) in order to relieve themselves and the community of costly or burdensome patients, Grisez and Boyle have concluded that “no safeguards” would ever be “perfectly adequate” to offset the risk of end of life abuses [emphasis added].

Even the most carefully crafted AVE legislation would offer “far too little protection” from what Yale Kamisar depicts as “not-so-necessary or not-so-merciful killings”. While more will be said on the need for comprehensive legislative safeguards in subsequent chapters, the fact that the once strict limitations imposed upon abortion (in the US and Australia) have been eroded over time has arguably undermined reassurances about strictly limited euthanasia practices.

Indeed, Robert H. Bork has implied that citizens who have come to support or otherwise tolerate the routine (and sometimes convenience based) killing of the

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75 Pellegrino, op.cit., p.98

76 G Grisez & JM Boyle, Jr., *Life and Death with Liberty and Justice – A Contribution to the Euthanasia Debate*, University of Notre Dame Press, London, 1979, p.173


79 B Pollard, *Euthanasia – Should We Kill the Dying?*, Regent House, Crows Nest, 1989, p.47. Please note that the abortion ‘link’ is explored in Chapter Four of this thesis.
unborn, are perhaps less likely to remain opposed to the non-voluntary or involuntary euthanasia of the grotesque and/or burdensome terminally ill.⁸⁰

Although it is uncharacteristic of reform advocates to do so, James Rachels has conceded that there could be no “definitive” assurance that the legalisation of AVE would not lead to “terrible consequences”.⁸¹ This worst case scenario has, more typically, been downplayed by others including Charles McKhann who has asserted that while some patients may be vulnerable to abuse, actual mistreatment “would be rare”.⁸² Peter Singer has also sought to reassure euthanasia reform critics that the risk of “unwanted consequences” remains very “small” and “finite”.⁸³ In fact, there appears to be a broad agreement amongst pro-choice lobbyists that their slippery slope counterparts have an unduly alarmist and pessimistic view of human nature.⁸⁴ R.G. Frey, in particular, insists that slippery slope advocates wrongly assume that society must fall into corruption on the issue of legalised euthanasia, “whether or not we engage in the quasi-logical task of concept clarification and line-drawing”.⁸⁵ It is essentially implausible, Frey adds, that citizens would fail to “note [the] moral differences between cases and mark them with safeguards that resist descent down a


⁸¹ Rachels, The End of Life, p.173

⁸² McKhann, op.cit., p.165


⁸⁴ South Australian Voluntary Euthanasia Society (SAVES), Inc., The Right to Choose, p.24

slope of killing”. Ronald Dworkin has similarly emphasised that a preoccupation with the threat of unsolicited terminations fails to take into account “how and why people care about their deaths”. Indeed, it is argued that the same humanitarian motivations which underpin a liberal society’s compassion driven AVE reform agenda, would invariably be aroused against an arbitrary practice such as involuntary active euthanasia. As long as communities remain clear about the compassionate motivation behind end of life legislative objectives, then it is maintained that apprehensions about a slippery slope debacle are unwarranted.

Evidence from Oregon (where Physician Assisted Suicide (PAS) is exempt from criminal liability) has tended to undermine slippery slope predictions, as statistics indicate that just 292 citizens had undertaken State sanctioned PAS during the 1998 to 2006 period. Whilst it remains true that assisted suicide deaths have risen from an initial 5.5 per 10 000 fatalities in 1998, to 14.7 in 10 000 by 2006, this more recent figure still equates to around 1 out of every 800 of the State’s annual deaths. Critics have, nevertheless, seen fit to focus on Death with Dignity Act (DWDA) participants who have undertaken PAS because

86 Frey., op.cit., p.59
87 Dworkin, Life’s Dominion, p.217
of their unease about being a burden upon their family and caregivers, or because of a loss of autonomy and physical control, rather than strictly in response to the arguably more compelling motivation of intractable pain. As a result of this admittedly disturbing trend, there is a risk that permitting autonomy driven PAS terminations will lead to an expectation that personal liberty trumps all other considerations in end of life decision making. This, in turn, could mean that arguably non-compelling PAS procedures may ensue, with implications including the premature death of patients and the unwarranted diminishment of the sanctity of life ethic.

In contrast with Oregon’s relatively modest PAS statistics, initial data from the Netherlands (1990) Remmelink Report appeared to vindicate the concerns of the anti-reform lobby after some 450 out of a documented 1350 active euthanasia terminations had purportedly been undertaken without the explicit consent of the patients involved. In 82 per cent of AVE (and PAS) procedures, the presiding physician illegally certified that terminated patients had died a ‘natural’ death (allegedly) in order to avoid the risk of formal investigation and/or potential legal liability. The Euthanasia and Other Medical Decisions survey added fuel to concerns that medicalised killing in the Netherlands was getting out of hand, when it was reported that PAS and AVE procedures rose from 2700 in 1990 to 3600 cases in 1995. While the number of patients terminated without their

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93 ibid., p.106

94 ibid., p.113

95 ibid., p.127
request declined over this period, non-voluntary active euthanasia still accounted for 900 deaths of which 15 per cent of patients did not have a specific discussion about the possibility of having their lives ended.\textsuperscript{96} The implication that the voluntary nature of AVE is occasionally being compromised has been strengthened by additional allegations that some patients have been persuaded to undertake a termination either because of a fear of abandonment by their family, or in order to avoid their wrath for imposing an unwanted burden upon them.\textsuperscript{97} Claims that some physicians are failing to consult with another colleague on an assisted death and recent (2007) confirmation that as many as 20 per cent of Dutch ‘voluntary’ euthanasia cases continue to go unreported have also been seized upon by critics as an indication that the Netherlands’ is on a slippery slope toward active euthanasia abuses.\textsuperscript{98}

Despite legitimate concerns about the lack of accountability amongst some physicians, it is testament to the Dutch authority’s determination to ensure that legislative guidelines are adhered to that the country’s liberal euthanasia laws have not resulted in an increased rate of non-voluntary euthanasia terminations when compared to other Western countries where


active euthanasia is prohibited.\textsuperscript{99} Slippery slope arguments have been further undermined by statistical evidence that the number of euthanasia terminations actually reduced from 3,500 in 2001, to 2,300 in 2005.\textsuperscript{100} Moreover, the Ministry of Health, Welfare and Sport has reported that only a third of all euthanasia requests are approved of while the remaining two thirds of patients are provided with alternate (treatment) options.\textsuperscript{101} Of those patients who are authorised to end their life, the vast majority (or some 90 per cent) who go through with an AVE procedure are suffering from terminal cancer.\textsuperscript{102} While this data suggests that slippery slope allegations may prove unsustainable in the longer term, it bears emphasis that the integrity of the Dutch system continues to face challenges from those who desire a more inclusive end of life regime.

Dutch credibility in end of life affairs was arguably diminished by the Netherlands Supreme Court’s lenient ruling in relation to the (1991) PAS death of depressed patient Hilly Bosscher. While the psychiatrist involved in this precedent setting \textit{Chabot} decision was convicted—albeit without penalty, it was revealed that his involvement in a depressed yet otherwise healthy patient’s assisted suicide death was rationalised on grounds that unmitigated psychological distress may be construed as a legitimate form of “unbearable


\textsuperscript{100} Boer, op.cit., p.551


While Dr. Chabot was reprimanded for having failed to insist that therapy was a preferable alternative to PAS and for not ensuring that Bosscher was personally appraised by a fellow psychiatrist, critics have since argued that patients diagnosed with major depression should be labelled as incompetent and, therefore, exempt from an assisted suicide option. Given the importance of rational decision making in end of life affairs, it is perhaps surprising that the Dutch authorities have more recently exhibited a willingness to tolerate a right to die amongst patients afflicted with debilitating Alzheimer’s disease. Although the Government maintained that this condition “is not in itself a reason to comply with a request for termination of life or assisted suicide”, the British Medical Journal reported in May 2005 that a Regional Assessment Committee approved of a 65 year old Alzheimer patient’s request for PAS. In this particular instance, the patient in question was characterised as an informed individual who was experiencing intolerable suffering due to a loss of independence and declining future prospects. Indeed, the Dutch Minister of Health Welfare and Sport later conceded that this assessment process met the required medical consensus that the patient’s “unbearable suffering” offered “no prospect of improvement”. While some would argue that it was appropriate for a right to die option to be extended to an afflicted patient who was not suffering from irremediable physical pain, it bears emphasis that exposing physicians to a

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103 Ministry of Foreign Affairs, Q & A Euthanasia. See further WJ Smith, Culture of Death – The Assault on Medical Ethics in America, Encounter Books, San Francisco, 2000, p.110


105 Ministry of Foreign Affairs, Can anyone request Euthanasia?.


107 Ministry of Foreign Affairs, Q & A Euthanasia.
culture where medicalised terminations are no longer exceptional but increasingly commonplace is potentially problematic.

**The Nazi Connection**

The question of whether physicians can become desensitised to killing was arguably confirmed in Nazi Germany, with medical authorities employed to systematically exterminate the nation’s most dependent (sickly or disabled) citizens under the guise of the Tiergartenstrasse (T4) ‘euthanasia’ programme.\(^\text{108}\) In spite of the fact that these crimes were committed under the auspices of a brutal authoritarian regime, Wesley J. Smith insists that a similar hard-line *utilitarian* mentality is still active today amongst the medical fraternity and bioethics advocacy. Indeed, the tendency of leading bio-ethicists (including Joseph Fletcher, Peter Singer, and Helga Kuhse) to characterise the value of human life in terms of its utility or personhood potential has been credibly depicted by Smith as paving the way for the legitimisation of non-voluntary and involuntary terminations.\(^\text{109}\) The idea that some lives are expendable is informed by the contentious assumption that an individual only achieves the status of *personhood* if they are a “rational and self-conscious being”.\(^\text{110}\) It follows, therefore, that “right to life” claims for individuals who lack awareness of themselves as “a being existing over time or as a continuing mental self” are not sustainable.\(^\text{111}\) The existence of some “biologically alive” individuals (consider, for


\(^{109}\) Smith, op.cit., pp.45–46


\(^{111}\) Singer, *Practical Ethics*, p.183
example, an anencephalic infant born with an incomplete brain) are, according to Peter Singer’s utilitarian rationale, of “no intrinsic value”. John Harris has joined Singer and Joseph Fletcher in arguing that in these sorts of extreme cases, there is a legitimate place for NVAE, because it is not wrong to humanely terminate “creatures that cannot value their own existence”. Harris has specifically identified persistent vegetative state (PVS) patients as potential NVAE candidates, because these individuals are allegedly “absent” from their body. Non-voluntary euthanasia is similarly characterised by Derek Humphry as offering a “better alternative” to the futile “medical hell” of an irretrievably moribund or perpetual vegetative existence. The problem in sanctioning arguably beneficial yet non-consensual terminations is, however, that the right to life for all patients would likely be diminished.

The fact that highly regarded German physicians were equally inclined to view certain patients as expendable ensured that very few practitioners refused to participate in the Nazi ‘euthanasia’ programme. In fact, Victor Sidel reported that “overt” opposition to the T4 operation was decidedly “rare”. An insight into the psyche of T4 participants was later

112 ibid., p.192. See further Singer, Rethinking Life and Death, pp.38–39
115 Humphry, op.cit., p.108
provided by Dr. Heinrich Bunke who sought to absolve himself of responsibility for illicit ‘mercy’ killings on grounds that he was only “following orders”. More alarming was colleague Aquilin Ulrich’s candid depiction of himself as a willing worker in the extermination of individuals who allegedly “stood below the level of animals”. These admissions would arguably have come as no surprise to the German people, as Robert Proctor has observed that this ‘secretive’ euthanasia programme attracted “broad…public support throughout the country”. In fact, Proctor’s research revealed that “many” Germans took the opportunity to request that their ‘suffering’ family members be relieved of their burden via an active termination.

While the Nazi analogy has inspired allegations that virtually any society is capable of rationalising euthanasia abuse, it could be credibly counter-claimed that the notion of ‘euthanasia’ (as it traditionally pertains to a ‘good’ or beneficent death) was shamelessly exploited by the German authorities. In particular, James Rachels insists that Germany “never had a policy of euthanasia” as we know it today, because the interests of the patient were superseded by the needs of the State. It is credibly maintained, therefore, that it is inappropriate to compare the modern AVE movement’s humanitarian agenda to that of a regime that exhibited an attitude of indifference to individual rights. Contemporary calls for legalised AVE are, more to the point, often informed by a diametrically opposed

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119 Proctor, *op.cit.*, p.194

120 Feinberg, *Freedom and Fulfilment*, p.293

121 Rachels, *The End of Life*, p.178. See further Fletcher, *Humanhood*, p.150

individualistic rather than a politically motivated corporate or strictly utilitarian philosophy.\textsuperscript{123} Derek Humphry and Ann Wickett insist that this situation is unlikely to change if citizens continue to “nurture” their “democracy” and strive to protect “humanitarian principles”.\textsuperscript{124} If policies and practices are “openly discussed” and legislation is arrived at by a democratic process, then O. Ruth Russell agrees that people need not fear the “indefensible” claims of an inevitable Nazi digression.\textsuperscript{125} The “dread” and “moral loathing” that this unparalleled historic account typically invokes will, says Marvin Kohl, help to ensure that citizens remain sensitive to unsolicited and unwarranted euthanasia practices.\textsuperscript{126} Of course, these seemingly compelling slippery slope counter-claims are very much reliant upon an assumption that it is possible to achieve a satisfactory balance between individual interests and preserving a ‘morally upright’ collective conscience in end of life affairs. Whether or not this is a reasonable expectation is a matter that will be explored in the chapters to follow.

**Conclusion**

In light of the fact that any dilution of the sanctity of life principle has potentially profound implications for the welfare of patients, this pro-choice discussion has highlighted some of the benefits and risks associated with AVE reform. While it was suggested that a last resort AVE option would provide an ideally dignified end to an otherwise intolerably tormented and futile existence, concerns were raised about the fact that some requests may be

\textsuperscript{123} Harris, *The Value of Life*, p.36

\textsuperscript{124} Humphry & Wickett, op.cit., p.35

\textsuperscript{125} Russell, op.cit., pp.226–227

motivated by external interests and pressures or because of a patient’s underlying psychological condition. While it was suggested that these factors needed to be dealt with, it was conceded that trust between some patients and their doctor could still diminish even in a carefully monitored post-AVE reform climate. This concern was portrayed as of secondary importance, however, to the more pressing need to offer beneficent last resort choice in dying. A note of caution was, nevertheless, expressed that autonomy alone should not be the primary motivation for a termination procedure, as there was a potential for an increasingly permissive and subjective right to die culture to ensue. Aside from the need for limited termination eligibility and a stringent screening process, reports of unrequested and unreported euthanasia deaths in the Netherlands were featured as a salutary reminder that physicians must be held publicly accountable for their involvement in patient terminations. Although there was some reassuring evidence of a decline in the number of euthanasia procedures, it was argued that the willingness of Netherlands’ authorities to admit intolerable psychological torment as a justification for AVE or PAS was potentially problematic. Indeed, it was suggested that there is a risk that physicians may become desensitised to increasingly routine medicalised killing which could, in turn, lead to the same sorts of callous or utilitarian rationales that underpinned Nazi Germany’s ‘euthanasia’ programme.

Despite assurances that contemporary arguments in favour of choice in dying tend to be grounded in an individualistic rather than a strictly State-centric cost–benefit philosophy, bioethicist espoused personhood agendas were cited as a threat to the medical profession’s commitment to the sanctity of life. It was, in fact, suggested that if an advanced society such as Germany was capable of rationalising non-voluntary and involuntary euthanasia on a questionable greater good basis, then other Western societies may also be vulnerable to euthanasia abuses. While it bears reiteration that pro-choice lobbyists have hinged their ‘no
comparison with Nazi Germany’s claims upon a belief that enlightened citizens of today would instinctively oppose unrequested euthanasia practices on liberal humanitarian grounds, the next chapter will investigate the credibility of this assumption with the aid of John Stuart Mill’s influential liberal thesis—*On Liberty*. While it will be made apparent that Millian liberalism advocates in favour of the individual and their right to rational self determination, it will be argued that the risk of an over-emphasis upon autonomy as a means of achieving the good *without* an adequate sense of moral accountability, may well leave patients vulnerable to the kinds of active euthanasia abuses alluded to in this chapter.
4 EUTHANASIA AND MILLIAN LIBERALISM

Introduction

It will be argued here that advocates of AVE reform tend to defend their position on grounds of autonomy centred personhood and yet, this discussion will go beyond a simple endorsement of this (liberal) position by expressing reservations about liberalism’s capacity to constrain questionable end of life practices. In order to provide a context for this debate it is fitting to consider the liberal scholarship of John Stuart Mill given his defining influence upon contemporary Western views on individuality. Although it is contentious whether Mill’s seminal work On Liberty is supportive of AVE, this discussion will set out to demonstrate that it is. In as much as this ‘in principle’ endorsement of end of life choice is welcome, On Liberty’s innately flexible and sometime ambiguous policy prescription will, nevertheless, be critiqued for its inability to ensure adequate moral accountability. Indeed, it will be argued that AVE advocates would be unwise to place undue faith in liberal society’s capacity to resist slippery slope potentialities, as Millian doctrine is inherently vulnerable to the rationalisation of more extensive (unrequested) active euthanasia procedures. For this reason, emphasis will be placed upon the need to lean less upon the notion of liberal beneficence, and more on robust legislation that specifically excludes (arbitrary) non-voluntary and involuntary euthanasia procedures.

Liberty and Human Flourishing

There is broad agreement amongst political analysts that John Stuart Mill’s portrayal of liberty (as an indispensable component of human flourishing) has substantially influenced
contemporary Western attitudes on the matter of individuality. In particular, *On Liberty’s* principle claim that *rational* adults are ideally situated to identify their own interests more effectively than anyone else has touched a chord with citizens who share a conviction that the ‘good life’ is a self prescribed pursuit. The notion that people should be free to “grow and develop” according to the “tendency” of their own “inward forces” was, more particularly, depicted by Mill as an appropriate response to the equally compelling observation that “Human nature is not a machine to be built after a model”. Any suggestion that social convention and custom should be permitted to usurp individuality was, thus, advised against on grounds that it tended only to breed under-developed characters such as could be found amongst the “cramped” and mentally “dwarfed” devotees of (Calvinistic) religion. Mill’s aversion to stifling conformity naturally had implications beyond the singular issue of character development, as *On Liberty* further stipulates that the so called “despotism of custom” unduly impaired the capacity of citizens to challenge the often “uncontested…truths” that informed outmoded values and traditions.

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3 ibid., p.123 [3:4]


The Pursuit of Progress

In order for individuals to determine if alternate beliefs and practices were better suited to contemporary needs, Mill declared that society must first be willing to provide “the freest scope possible to uncustomary things”.⁶ Having once liberated the people to investigate unorthodox alternatives, it was anticipated that the combination of experience and objective thought would conspire to expose “wrong opinions and practices” in favour of more compelling “fact[s] and argument[s]”.⁷ Where traditional conceptions of the ‘good’ derived from “Nature” or the “ordinance of God” were found to be demonstrably inadequate, Mill proposed that the average individual’s self-prescribed rational “preference” provided a “perfectly satisfactory” substitute on matters of “morality, taste, or propriety”. Whilst Mill was sure to clarify that citizens should not seek to gain assent for conduct which “universal experience” had already “condemned”, it was deemed equally fitting that the burden of proof against (potentially) beneficial proposals ultimately rested with the proponents of the status-quo.⁸ Those who remained antagonistic to arguably progressive agendas on grounds of mere conjecture or without reasonable justification were rebuked by Mill, just as AVE lobbyists of today level accusations of obstructionism and antiquated thinking against their tradition bound opponents.⁹ Indeed, the strongest criticism is typically reserved for the arguably illiberal assumption that the traditional

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Liberty and the Slippery Slope

The anti-AVE lobby’s willingness to impede freedom of conscience on sanctity of life grounds has not, however, diminished the resolve of pro-choice commentators who maintain that rational patients have a right to retain reasonable control over their end of life affairs. Indeed, it is asserted that the decision to forfeit a life of intolerable pain and futility is a distinctly personal decision that must be made in accordance with a patient’s own unique values and interests. Advocates typically maintain that this is not a radical ideal but rather, an acknowledgement of democratic diversity and human rights. It is no small irony, therefore, that politicians continue to overlook choice in dying in deference to the arguably less compelling belief that life itself takes precedence over expressions of self regarding rational free will. Fearing that any conceivable benefit from the legalisation of AVE would only be achieved to the irrevocable detriment of the sanctity of life ethic, pro-


sanctity of life credo should remain exempt from correction despite mitigating experience and evolving social insights.
life lobbyists insist that vulnerable patients would be placed at an unacceptable risk because the prohibition against non-voluntary active euthanasia (NVAE) would also come under increasing scrutiny.14 Whilst this argument was outlined in the preceding chapter of this thesis, it bears reiteration that slippery slope exponents are chiefly criticised for failing to account for citizens’ capacity to differentiate between beneficent AVE and unwarranted or arbitrarily imposed end of life practices.15 In spite of their scepticism, it has been repeatedly affirmed by pro-choice lobby groups that their support for active voluntary euthanasia is consciously distinguished from the more radical agendas of bioethicist commentators who favour non-voluntary euthanasia procedures.16

The evidence at hand suggests that AVE reform advocates rely heavily upon an assumption that ‘enlightened’ liberal communities would be intuitively opposed to more extensive (arbitrary) NVAE terminations.17 In principle agreement is provided by Mill, having concluded that it defied credulity that a free and open society that had already “got the better of barbarism” would willingly permit “degenerate” practices (which might reasonably encompass unrequested active euthanasia) to overrule fundamental values such


15 N Biggar, Aiming to Kill – The Ethics of Suicide and Euthanasia, Pilgrim Press, Cleveland, 2004, pp.120–164


17 Russell, op.cit., p.227
as the right to life. Additional allegations that citizens could inadvertently miscalculate the consequences of legislative reform were viewed by Mill as not entirely convincing, given the average person’s capacity for reason and prudence. While reform advocates assume that reason can be relied upon to direct citizens to pursue equitable policy outcomes, a more cautious appraisal would acknowledge that this level of confidence is not entirely warranted as ‘prudent’ opposition to NVAE (in a post-AVE climate) could well be construed as discriminatory. More specifically, incompetent patients suffering from a similar ailment to that of competent others (who have opted for an AVE procedure) arguably could not be excluded from the same ‘benefit’. Despite the fact that a pluralistic liberal citizenry may conflict on the legitimacy of imposing allegedly ‘beneficial’ NVAE procedures, it seems likely that a permissive rather than conservative determination is the most probable outcome in a culture where medicalised terminations have already acquired popular public assent. If society is to resist this process of gradualism, it is suggested that reliance upon the better judgment and beneficent nature of liberal citizens must be underpinned by a countervailing commitment to enforce firm legislative restrictions in end of life affairs.

22 Biggar, op.cit., p.151
The Limits of Liberty – Interests and Harm

Despite the fact that liberalism fails to instil complete confidence that a slippery slope scenario can be averted, it must be conceded that Millian doctrine does offer some guidance in the fight against potentially harmful activities such as NVAE. Indeed, *On Liberty*’s optimism regarding the propensity of citizens to behave in a prudent fashion is tempered by the judicious proviso that deviant elements must be held “accountable” for “manifestly pernicious” behaviour (such as “selfish indifference”, “cruelty” and “malice”) or for actions which serve to undermine “the security of…society” more generally. Mill further maintained that the “only freedom” which could be ascribed as legitimate, involved practices which did not “deprive” or “impede” others in the pursuit of their respective interests. While it is apparent that this ‘interests doctrine’ is sufficiently ambiguous to accommodate contested interpretations, it does succeed in demonstrating Mill’s desire to preserve socially recognisable needs or those indispensable factors which help to contribute to a successful and fulfilling life. More to the point, the implicit relationship that exists between the preservation of interests and individual well-being gives rise to a conclusion that unsympathetic treatment would result in enduring loss or substantial harm.

[23] ibid., p.164


Mill’s depiction of harm in terms of *physical rather than moral injury* was motivated by a conviction that “self-protection” and personal “security” are “the most vital of all [human] interests”\(^{28}\). It would be improper to assume that this is an endorsement of anti-AVE philosophy, however, as this sentiment can be readily applied to serve claims on either side of the euthanasia debate. For instance, the pro-AVE lobby maintains that a person’s interests are only truly secure when they are at liberty to pursue a beneficent last resort good death. Although AVE opponents typically share the desire to ensure that patients experience a pain free dying, it appears that they are willing to compromise this objective in deference to concerns that legalised ‘mercy killing’ would distort or dilute public perceptions of harm. Of course one could argue that Mill provided safeguards designed to enforce minimum standards, having differentiated between so called self regarding harms which involve actions that affect no one but the agent themselves, and that of ‘other regarding’ harms which imply an “encroachment” on a fellow individual’s rights, an “infliction” of “any loss or damage not justified [by one’s] own rights”, or “selfish abstinence from defending [others] against injury”.\(^{29}\) The fact of the matter is, however, that agreement on precisely what actions or inactions are *harmful* at a self or other regarding level remains elusive as (end of life) ‘harm’ interpretations are often grounded in conflicting moral assumptions.\(^{30}\) More specifically, there is fundamental disagreement

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between those who conceive AVE as an ultimate violation of a patient’s interests and that of their counterparts who are convinced that this last resort option is a merciful and rightly self determined response to intractable terminal suffering. The fact that neither side is prepared to compromise their position would seem to suggest that conflicting end of life agendas cannot be satisfactorily resolved by On Liberty’s eminently contestable ‘interest’ and ‘harm’ doctrines.

**The Sovereignty of the Individual**

In spite of Millian liberalism’s unresolved ‘harm’ debate, it appears that Mill would have resisted the urge to label beneficent AVE as a self or other regarding violation—in part—because of a conviction that “the mere cessation of existence” constituted “no evil to anyone”.\(^{31}\) Mill’s desire to have control over the timing of his own passing as being eminently preferable to the spectre of a “slow” and distinctly “odious” dying is perhaps even more significant.\(^{32}\) Indeed, On Liberty’s endorsement of the rational individual’s right to remain “sovereign” over their “own body and mind” arguably implies that intimate life (and death) choices should remain within the control of the individual concerned.\(^{33}\) This issue is somewhat clouded, however, in that the intentional termination of life appears to contradict Mill’s equally emphatic assertion that “It is not freedom to be allowed to alienate [one’s] freedom.”\(^{34}\) While this particular statement was made within the specific

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\(^{34}\) ibid., p.173 [5:11]
context of *slavery*, this distinction is lost on those who argue on principle that the permanent deprivation of an individual’s capacity for autonomous action (via active euthanasia) is *always* an unmitigated harm.\(^{35}\) What this contentious interpretation overlooks, however, is that slavery implies the “life, liberty, and fortune of an individual is held within the absolute power of another”.\(^{36}\) With the notable exception of a patient’s right to refuse extraordinary treatment, the parallels between slavery and the enforced denial of a desired ‘good death’ are self-evident. Even if one concedes that opposition to wilful enslavement is motivated by a laudable commitment to protect people from entering into an arrangement that they may later regret, an intolerably distressed terminal patient’s decision to end their life is uniquely different. Unlike slavery, *last resort* AVE inflicts no injury upon an individual’s interests because they have already reached the point where the opportunity to flourish is no longer a realistic possibility.\(^{37}\) The commonly invoked counter-claim that the freedom to permanently surrender one’s autonomy is an undignified and contradictory undertaking, merely demonstrates the anti-AVE lobby’s reticence to acknowledge that it is the rational and informed patient themselves who is ideally situated to adjudicate on this particular issue.\(^{38}\)

It bears emphasis that *On Liberty’s* preference for minimal authoritative intrusion in individual affairs was *not* intended to imply that people should act without any thought to

\(^{35}\) Callahan, op.cit., pp.174–175

\(^{36}\) McLean (ed.), op.cit., p.453


consultation.\textsuperscript{39} In fact, Mill was amongst the first to concede that “Human beings owe to each other help to distinguish the better from the worse, and encouragement to choose the former and avoid the latter.”\textsuperscript{40} A sympathetic pro-AVE lobby has, subsequently, argued that every effort should be made to ensure that patients considering the option of active euthanasia only do so within the context of sound medical advice and following discussion with family and suitably qualified counsellors.\textsuperscript{41} In those instances where the advice provided conflicts with the patient’s preference for an orchestrated AVE death, it is evident that they must either submit to current legal constraints or else take matters into their own hands. In the latter instance, it appears that Mill would have argued in favour of the idea of permitting the patient to expose themselves to (self regarding) moral or physical harm, as preferable to that of imposing unwelcome paternal constraint.\textsuperscript{42}

\textit{On Liberty}’s portrayal of a precariously placed bridge occupant famously illustrates the text’s emphasis upon an anti-paternalistic agenda, with Mill remarking that “no one but the person” themselves has the right to “judge…the sufficiency of the motive” that inspired their decision to alight or remain on this ostensibly unstable structure.\textsuperscript{43} Although it was freely conceded that the desire of an onlooker to perform an act of “individual beneficence such as saving a fellow creature’s life” was not without merit, any such intervention was only warranted in instances where the person at risk was unaware of their imminent


\textsuperscript{40} ibid., p.142 [4:4]

\textsuperscript{41} Russell, op.cit., p.276


\textsuperscript{43} ibid., p.166 [5:5]
disaster or mentally incompetent [emphasis added]. 44 Mill defended these discretionary limitations on grounds that all “errors” a rational and informed person “is likely to commit against advice and warning are far outweighed by the evil of allowing others to constrain him to what they deem his good” [emphasis added]. 45 This apparent disbarment of (anti-AVE) claims that an individual’s perceived good pre-empts freedom of choice is by no means a revolutionary concept, as the legal right of US and Australian citizens to reject medical treatment is an explicit validation of this principle. The fact that some patients would prefer to bring a speedier end to their life and yet are incapable of doing so, merely reiterates the need for sympathetic physicians to be in a position to legally assist them in the realisation of this Millian compliant objective.

**Liberty and Tolerance**

It is increasingly evident that the pro-life lobby’s commitment to scuttle popularly supported AVE reform would have prompted expressions of protest from Mill. In particular, *On Liberty’s* warning against the “injustice” of unduly invasive agendas arguably invites anti-AVE lobbyists to contemplate the fact that they too are not exempt from unwelcome paternalistic pressure. 46 Despite that fact, Mill’s petition for tolerance in the face of a “diversity of opinions” has often fallen on deaf ears. 47 Indeed, pro-life advocates insist that AVE reform proposals are driven by radical civil libertarians who

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have no compunction in imposing an abhorrent end of life ethic upon the entire community. In failing to recognise that there is also a cost or harm involved in maintaining the legislative status-quo, anti-AVE advocates make no room for compromise. While On Liberty argues that citizens have a right to express moral outrage against individual actions that they deem as “foolish, perverse or wrong”, Mill would likely have encouraged anti-AVE lobbyists to restrict their interference to the extent of “stand[ing] aloof”, offering advice, or otherwise articulating a sense of “distaste”. Indeed, the voicing of “unfavourable opinion” was not permitted to manifestly oppress an ‘offending’ party’s “individuality” and, most particularly, when it was within the power of a disgruntled onlooker to pursue the company of other more “acceptable” persons. This commitment to defend self regarding “mischief” from unduly invasive tactics also extended to a willingness to accommodate wilfully entered into (liberty enhancing or liberty violating) other regarding activities. In particular, Mill’s acknowledgement of the controversial practice of polygamy demonstrates that his primary concern was that any such arrangement was freely entered into and could just as readily be dissolved at the behest of the individual(s) concerned. This same circumspect principle is equally apparent in all credible AVE reform proposals, as self determining (eligible) patients and practitioners are imbued with the right to enter into or withdraw from a termination agreement at any time.

48 Grisez & Boyle, op.cit., p.49


50 ibid., p.144 [4:5]

51 ibid., p.148 [4:10]

52 ibid., pp.160–161 [4:21]
Liberty and Virtue

Although frustrated AVE reformers might beg to differ, Millian analyst Gertrude Himmelfarb maintains that individual liberty has today established itself as “the only moral principle that commands general assent in the Western world”.\(^{53}\) Whilst one could be forgiven for assuming that Mill would have welcomed this trend, *On Liberty’s* call for “strong impulses” to be “properly balanced” by a “love of virtue” and a sense of “self control” indicates a more diverse ambition.\(^{54}\) Mill’s interest in nurturing individuality and moral character is, in fact, evidenced in *On Liberty’s* reference to the fundamental “importance [of] not only what men do, but also what manner of men they are that do it”.\(^{55}\)

A virtuous citizen was duly characterised as one who recognised the more pertinent lessons of tradition, as it was conceded that (Western) society “owe[d] a great debt” to Judeo-Christian morality because certain “influences of religion on the character” were broadly beneficial.\(^{56}\) Having specifically cited Christian “self government” and “self denial” as “elements of human worth”, Mill consciously added that “Pagan self assertion” provided a crucial counter-balance to values that might otherwise lead to an attitude of excessive abnegation.\(^{57}\) Indeed, this vision of a regenerated yet morally sensitive individualistic ethic was informed by Mill’s underlying desire to see “well doing” prevail in the struggle

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\(^{55}\) ibid., p.123 [3:4]


against “evil”. It was implied that this was an achievable objective, because the virtuous attributes of “justice” and “beneficence” purportedly resided within the “intellect and feelings of every good man [and] woman”. In fact, Mill’s *Utility of Religion* text disclosed that there was absolutely “no danger” that these or other qualities such as compassion or “doing as we would be done by”, would ever be universally abandoned.

**Liberty and Human Nature**

Arguably idealistic assumptions about the moral integrity of citizens left Mill open to criticism from James Fitzjames Stephen, having maintained that Mill harboured “too favourable an estimate of human nature”. This allegation is, nevertheless, challenged by a number of more pragmatic Millian statements including one from *The Subjection of Women* in which Mill concedes that “Absolute…angels” were rare and “ferocious savages” are “very frequent”. An equally pertinent view was espoused in *Utilitarianism*, with Mill drawing the sobering conclusion that the willingness to uphold the good of others was “in most individuals…inferior in strength to their selfish feelings and is often wanting altogether”. If Mill was right to assume that an individual’s regard for their own interests is a far more “constant” and “universal” trait than the inclination to respect the interests of others, then it is apparent that *On Liberty’s* advocacy of virtuous behaviour provides no

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60 Stephen, op.cit., p.49


62 Mill, “Utilitarianism”, p.306
guarantee that moral ends will prevail.\textsuperscript{63} While the principle of interdependent self interest was characterised by Mill as a means of ensuring that less conscientious citizens maintained a healthy regard for the interests of their neighbours, this too is far from a conclusive solution to other regarding harms and particularly in cases where one party is in a position to benefit to the contrasting detriment of another.\textsuperscript{64} In fact, On Liberty’s complicity in fostering resentment towards the restraining influences of custom and a suspicion of authority arguably plays into the hands of less scrupulous individuals, as it inadvertently encourages a culture where moral accountability is perceived as an optional ideal that may, or may not, serve one’s own interest based objectives.\textsuperscript{65} Indeed, Mill’s inability to anticipate an era in which moral ‘absolutes’ are increasingly viewed as subjectively devised or tentative, and stabilising institutions (such as the Church) have lost much of their influence to competing interests, has effectively meant that On Liberty’s virtuous citizenry concept is difficult to sustain.\textsuperscript{66} Even if one were to maintain that there is only an element of truth in this admittedly pessimistic assessment, it is clearly in the interests of all citizens to ensure that a potentially problematic practice such as (legalised) AVE is scrupulously supervised and deviant behaviour is promptly dealt with.


\textsuperscript{64} Mill, “Utilitarianism”, p.304

\textsuperscript{65} Himmelfarb, On Looking into the Abyss, p.91

The Problem of Moral Ambiguity

It could be argued that *On Liberty*’s alleged failure to adequately account for the human appetite for licence and self seeking has, in fact, engendered a citizenry that is antagonistic to self control and moderation. More to the point, it has been suggested that the decline in traditional moral standards that is evident today owes much to (Millian) liberal philosophy’s apparent lack of an adequate internal corrective. This can be explained on grounds that Mill’s commitment to moral plurality and the obligatory companion ethic of tolerance have arguably undermined citizens’ resolve to adjudicate against even illiberal activities such as convenience based abortions. Millian liberalism’s scepticism about the exclusivity of “Christian ethics”, in particular, has helped facilitate the legitimisation of this and other questionable practices, as *On Liberty*’s affirmation that no one moral code is capable of providing a “complete rule for our guidance” has effectively severed (secular) society from the indispensable notion of ‘universal’ moral arbitration. Mill’s willingness to accommodate moral diversity has, in turn, enabled a relativistic ethic to fill the vacuum left by moral absolutism. The consequences of this ‘cultural revolution’ are potentially

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68 Devlin, op.cit., p.108. See further Bork, op.cit., p.61 & p.63


71 Himelfarb, “Introduction”, p.48
disastrous, as an inability to reach agreement on how we define and interpret good and evil could conceivably lead to the unravelling of civil society.72

Given Millian liberalism’s tendency to cast morality as an inherently flexible concept and ethical consistency as a potential extreme, it is not surprising that so called progressive social practices and policies are increasingly tolerated in liberal Western societies.73 Indeed, this readiness to accommodate a plurality of conflicting moral interests has arguably resulted in deviancy being viewed in a more hospitable light.74 More to the point, Millian liberalism’s misgivings about moral absolutism have provided unorthodox elements and ‘progressive’ thinkers alike with an open invitation to discredit traditional moral values as intolerant and by implication—as perverse or unjust.75 It stands to reason that if moral conservatives risk being ostracised as prudish and bigoted for expressing their ‘recalcitrant’ views, then calls for them to remain silent or aloof could convey a message that all manner of outlandish activities are potentially permissible.76 An ensuing process of perpetual ‘moral slippage’ may follow, as the absence of a universally agreed upon moral credo erodes citizens’ capacity to rank and decipher between fundamental ‘moral’ claims.77 The implications of this impasse for vulnerable patients are significant, as liberalism’s

72 Devlin, op.cit., p.10


76 Devlin, op.cit., p.17

77 J Gray, “Introduction”, in, Gray (ed.), op.cit., p.xx
hostility toward moral absolutism may jeopardise fundamental human rights.\textsuperscript{78} This is a particularly relevant consideration when assessing the merits of AVE reform, as it is conceivable that the right to life could be subjected to a process of perpetual re-evaluation.

Concerns about active euthanasia practices going beyond AVE are not based upon mere speculation alone, as leading bioethicists have acknowledged their readiness to support unrequested active euthanasia terminations.\textsuperscript{79} Whilst more moderate pro-choice advocates are content to draw the line at voluntary euthanasia, \textit{On Liberty} provides no absolute guarantee against other more extreme non-voluntary agendas gaining credence, having stipulated that disgruntled citizens should be permitted to challenge the relevancy of established values and practices.\textsuperscript{80} Although Mill naively envisaged that this ‘auditing’ process would put to rest lingering doubts, there is always a risk that those who wish to promote non-conventional ideals may succeed in undermining indispensable moral boundaries. Indeed, it stands to reason that in a society where the principles of interest and harm mean different things to different people, one wonders whether unrequested (NVAE) end of life procedures could well become ‘normalised’ by virtue of the repeated endorsement of this (currently taboo) practice.\textsuperscript{81} Whilst a more optimistic analysis might conclude that public opposition to this type of arbitrary ‘mercy killing’ would remain steadfast, it is not out of the question that unrequested terminations may be rationalised in

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\textsuperscript{79} Please refer to Chapter Five for an indication of bioethicist views on NVAE.

\textsuperscript{80} Mill, \textit{On Liberty}, p.108 [2:34]

\textsuperscript{81} Mackay, op.cit., p.65
\end{flushright}
deference to allegedly ‘more compelling’ third party interests.\textsuperscript{82} For example, the abortion issue arguably demonstrates that citizens who are willing to absolve themselves of traditional (sanctity of life) constraints are a potential threat to the broader liberal ethic.

\textbf{The Issue of Abortion}

Given that liberal principles are commonly invoked in order to rationalise the (sometime unconscionable) practice of foetal terminations, opponents of abortion would likely see the irony in Mill’s warning that “the violent” and “undisguisedly selfish side” of human character is often reserved for use against “those who have no power to withstand it”.\textsuperscript{83} While it must be conceded that the ‘personhood’ of a foetus is a disputed concept, the practice of terminating evolving life in light of indeterminate assurances about this particular organism’s inability to experience fear and suffering at the hands of an abortionist also cannot simply be ignored.\textsuperscript{84} In fact, recent research findings reported in \textit{JAMA} have failed to allay legitimate concerns about foetal distress, having concluded that the ability of the foetus to experience pain is “unlikely before the third trimester”.\textsuperscript{85} In spite of this less than conclusive finding, some 1.5 million annual abortions are carried out in the US while in Australia there are an estimated 73 000 (and possibly even as high as 100 000) terminations a year, including a \textit{conservative} figure of around 660 (compared to between 1

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\item \textsuperscript{82} Smith, op.cit., pp.118–119
\item \textsuperscript{83} Mill, “On the Subjection of Women”, p.509
\item \textsuperscript{84} R Blackford, “The Supposed Rights of the Fetus”, \textit{Quadrant}, September 2002, pp.15–16
\item \textsuperscript{85} SJ Lee \textit{et al}, “Fetal Pain”, \textit{Journal of the American Medical Association}, Vol.294, No.8, 24/31 August 2005, p.947
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000 and 2 000 US) late term procedures. Suffice to say that these statistics have prompted Australia’s Health Minister Tony Abbott to declare the present rate of abortion as “a national tragedy”, while US President George W. Bush has more pointedly described late term procedures as “a terrible form of violence”. These latter (post 20 week) terminations generally involve a partial birth process that requires the abortionist to insert a scissor like instrument into the infant’s skull through which its brain matter is then expunged. Some second trimester procedures may incorporate an alternate saline injection directly into the amniotic sac which reportedly acts to kill the foetus over a period of about an hour. The very fact that these practices are undertaken without regard for (potential) foetal distress appears to discredit assurances that liberalism is a philosophy distinguished by its commitment to protect the vulnerable. It also provides us with a sobering reminder of just how defenceless terminal patients may be if legislative guidelines in support of State sanctioned AVE are in any sense inadequate. More to the point, one should not assume that citizens who are prepared to endorse or tolerate questionable abortions will be pro-active in supporting the continuing lives of burdensome patients.


88 Egan, op.cit., p.15 & Bork, op.cit., p.182


It may be a reflection of a growing disregard for life that credible research indicates that post-abortion distress is rare.\textsuperscript{91} This lack of remorse prevails in spite of the fact that an increasing number of women have seen fit to pursue their ‘right’ to undertake an abortion as a result of a \textit{minimal} foetal deformity (such as a cleft palate) or in response to psychosocial distress (including career related concerns) over an unwanted pregnancy.\textsuperscript{92} Rather than questioning the propriety of these seemingly irresponsible decisions, it appears that the liberal pro-choice lobby is preoccupied with ensuring that women are treated in a “non judgmental” and “supportive” environment that respects their “integrity”.\textsuperscript{93} Even in extreme ‘late’ abortion cases, Brid Hehir insists that women require “support and understanding, not condemnation, prevarication or moralising”.\textsuperscript{94} While it must be acknowledged that there will always be cases where a pregnancy termination is made viable in order to preserve a woman’s right to life, when abortions are administered on the basis of arguably \textit{non-compelling} grounds, one could conclude that any such undertaking is indicative of a distorted view of self regarding liberty and self interest.\textsuperscript{95} If ‘non-essential’ terminations are to have any credibility at all, then it is clear that a woman’s (moral and

\textsuperscript{91} M Ripper, “Abortion: The Shift in Stigmatisation from those seeking Abortion to those providing it”, \textit{Health Sociology Review}, Vol.10, No.2, 2001, p.74


\textsuperscript{93} Ripper, op.cit., p.76


legal) interests can only prevail if the foetus is firmly categorised as a ‘non-person’.  

Having made this assumption, On Liberty’s assertion that the violation of a “distinct and assignable obligation to any other person” is “amenable to moral disapprobation” can effectively be ignored. It is disconcerting, therefore, that this same minimal or no harm philosophy could be invoked in future to serve the agenda of those who are willing to dismiss right to life claims in favour of non-voluntary euthanasia procedures. After all, if Millian values can be invoked to destroy the life of an otherwise healthy foetus, it seems reasonable to suggest that the same level of sympathy and support might be afforded to those who wish to impose an active euthanasia termination upon problematic and unwanted patients.

**Vulnerable Patients**

Given that liberalised abortion rights prioritise the burden carrying party over that of the dependent individual, legislators must not assume that liberal values will automatically protect the sick and dependent from imposed active euthanasia terminations. In fact, Millian liberal doctrine effectively abandons patients who are categorised as non-persons because an individual is said to only possess a right when they can exhibit “a valid claim on society” that is protected “either by the force of law, or by that of education and opinion”. While it is true that Mill condemned those who are given to malicious

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98 Fletcher, *Humanhood*, pp.154–155

indifference, mere criticism alone does not absolve the problem of how liberal society controls those who perceive greater personal benefits to be had in dismissing the interests of others. Indeed, Mill’s counterpoised assertion that “general rules” of conduct would need to be “observed” in order to protect “All that makes existence valuable” is a largely deficient proviso, as it is at perennial risk of being eclipsed by the popularly supported (On Liberty) notion that restraint must not produce “evils greater than those which it would prevent”. It is equally apparent that this undertaking provides leeway for ‘progressive’ thinkers to find a reason to reject moral limitations (including rules aimed at prohibiting questionable liberties such as those involving non-compelling abortions or arbitrary NVAE procedures) on grounds of a real or perceived evil. Mill himself understood—yet appeared to have no definitive antidote for—the fact that the human “moral faculty” is “susceptible” of being directed to accept the “absurd” or “mischievous” with “all the authority of conscience”, and most especially if people perceive that it is in their own best interests to do so. Whilst this critique of Millian liberal doctrine is not intended to detract from the legitimacy of beneficent last resort AVE, it is clear that liberal society must remain steadfast in its opposition to non-voluntary and involuntary active euthanasia practices. This will prove to be an elusive objective, however, if we permit communal values and the rule of law to be tainted by a radicalised reformist agenda and a disproportionate emphasis upon tolerance, moral subjectivism, and (selfish) individualism. What is required instead, is a more principled ideal that will help to moderate Millian liberalism’s evident ‘moral’ shortcomings. In place of a doctrine that portrays morality as a negotiable and ever


102 Mill, “Utilitarianism”, p.303
evolving concept, alternate Kantian philosophy may be worthy of some consideration, as it proposes that all our decisions be shaped and informed within a strict framework of so-called perfect duties.

**A Kantian Alternative?**

At first glance, Kantian liberalism appears to provide an ethically superior alternative to that of Mill’s *On Liberty* as it rests upon a categorical imperative that people “Act only according to that maxim” that they could rationally acknowledge as “a universal law”. In particular, Immanuel Kant focussed upon the mutually beneficial ideal that one should never “treat humanity…as a means, but always at the same time as an end”. The contrasting cost–benefit utilitarian assumption (as favoured by Mill) that the “motivating ground for living is happiness” or in “satisfying inclinations”, was duly rejected by Kant as a flawed and uncertain basis for “moral rules”, ostensibly because “self regarding duties…are independent of all advantage”. Indeed, Kant insisted that “dutiful and amiable” actions lack “moral worth” if motivated by an “inner satisfaction” or mere “inclination”. The value of an action was, thus, wholly reliant upon the “principle of volition by which the action is done” rather than to the “faculty of desire”. In deference to this end, Kant maintained that it was needful for free will to be filtered through the

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104 Blackburn, op.cit., p.55


107 ibid., p.128
“moral law”, which is itself arrived at via the “judgment of reason”. Any claim that conflicted with this law was, subsequently, dismissed by Kant as invalid and impermissible.\textsuperscript{108}

While Kant was convinced that the good life could best be assured if citizens operated within a strictly delineated structure of fundamental rights and “objective rules”, it is noteworthy that Kant’s “rule of morality” specifically forbade the act of suicide on grounds that it is irrational to treat oneself as a means or in a manner that contradicts a maxim (i.e. the sanctity of life principle) which is recognised as “a universal law of nature”.\textsuperscript{109} A problem arises, however, in that this ‘perfect duty’ ideal conflicts with the more responsive views of (pro-AVE) commentators who maintain that genuine need overrides any obligation to an unduly demanding (Kantian) moral credo.\textsuperscript{110} Indeed, Kant’s assertion that moral worth should be evaluated strictly in terms of duty rather than in response to arguably subjective emotional motivations flies in the face of those who favour compassion driven AVE reform.\textsuperscript{111} In seeking to enforce a strict Kantian (sanctity of life and anti-AVE) ethic, policymakers would be compelled to discount legitimate self regarding sovereignty in favour of an unduly legalistic moral obligation.\textsuperscript{112} In so doing,

\textsuperscript{108} ibid., pp.130–131


\textsuperscript{110} Fletcher, Humanhood, p.168


Kant fails to concede that there are other obligations (such as justice and compassion) that transcend the duty to preserve life. While it has already been established that morally ambiguous Millian liberal doctrine places vulnerable patients at risk of an unsolicited termination, it is equally apparent that a Kantian alternative does not offer the level of choice that intolerably distressed patients typically desire. Although it is conceded that Kant’s perfect duty regime offers a welcome measure of policy ‘certainty’ that Millian liberalism is unable to provide, the fact remains that this benefit is negated by its unsympathetic response to end of life choice.

Conclusion

This discussion initially highlighted the Millian liberal argument that human flourishing is reliant upon rational individuals having the opportunity to formulate their own responses to intimate life and death decisions. As such, it was acknowledged that AVE advocates characterise the right to forfeit a life of intolerable pain and futility as not only a liberal principle but also a basic human right. This claim was brought into question, however, by anti-AVE commentators who maintained that any diminishment of the sanctity of life ethic would place vulnerable patients at an unacceptable risk. Whilst this allegation was refuted by AVE advocates as unsubstantiated scaremongering it was, nevertheless, argued that it would be unwise to rely upon Mill’s contested harm and interest doctrines to offset the threat of non-consenting terminations. Aside from the fact that one’s (potentially misguided) moral perspective would invariably prejudice harm and interest assumptions, this critique was further informed by an underlying scepticism about Mill’s unduly optimistic view of human beings as predominantly prudent and compassionate. Despite

\[115\] Fletcher, *Humanhood*, p.33
these reservations, it was conceded that Mill would have endorsed AVE on grounds that rational individuals have a right to remain sovereign over their own body and mind. Anti-AVE lobby attempts to invoke the Millian prohibition against autonomy ending slavery contracts were, subsequently, exposed as unconvincing as there was little chance that an informed and intolerably distressed (terminal) patient could conceivably regret instigating a timely end to their irremediable suffering.

Whilst there was never any question about the legitimacy of Mill’s tolerance for rational self regarding and mutually consensual other regarding (lawful) behaviour, On Liberty’s antagonism to the notion of a singular universal truth was, nevertheless, depicted as undermining crucial moral considerations. Indeed, it was alleged that liberal society’s endorsement of moral plurality and subsequent inability to agree on arguably indispensable end of life constraints provides an opportunity for the introduction of arbitrary or unwarranted non-voluntary and even involuntary active euthanasia practices. The fact that mitigating (absolutist) moral views are at risk of exclusion from the end of life policy debate on grounds that they are deemed as intolerant and unreasonable, was depicted as an equally unwelcome potentiality that could well serve the more radical active euthanasia agendas of ‘progressive’ minded bioethicists. Although it was conceded that On Liberty endorsed the notion of moral propriety it was, nevertheless, argued that Mill’s tolerance for a diversity of values and general scepticism about custom and paternal authority could lead to a diminishment of an ‘other regarding’ conscience. This issue was exemplified in the debate over liberal abortion rights, as it was suggested that society’s complicity in the practice of arguably ‘non-essential’ terminations without regard for the (potential) suffering of (alleged) ‘non-person’ foetuses demonstrated that citizens are capable of developing a distorted view of reasonable behaviour.
Mill’s endorsement of rules of conduct aimed at preserving fundamental individual interests were depicted as inadequate to offset other regarding euthanasia abuses, as this proviso is undermined by *On Liberty*’s overriding assertion that restraint must not produce evils greater than that which it seeks to redress. Indeed, this veritable invitation for disgruntled ‘progressive’ thinkers to expose real or perceived evil in established policy was identified as contrary to indispensable moral restraint in the longer term. While an investigation of Kantian liberal philosophy gave rise to the conclusion that this particular ethic provided a more certain basis for end of life policy, it was conceded that Kant’s commitment to the sanctity of life meant that neither he nor Mill provided a suitably reassuring or compassionate guide to terminal patient welfare. It was duly concluded that liberal societies considering the adoption of legalised AVE must maintain strictly defined policy boundaries that prohibit more extensive and arbitrary non-voluntary procedures. While these sorts of provisos will help to offset active euthanasia abuses, it became apparent that a companion ethic was needful to help constrain liberal citizens from rationalising questionable terminations. Toward that end, the chapter to follow will investigate whether utilitarian or communitarian philosophies can offer a more definitive and/or morally robust contribution to the administration of active euthanasia policy.
5  A UTILITARIAN AND COMMUNITARIAN ANALYSIS OF AVE REFORM

Introduction

It is often argued in related academic literature that utilitarianism has a legitimate and decisive part to play in the active voluntary euthanasia (AVE) debate. The following discussion will question this premise on grounds that utilitarianism encourages citizens to spurn the interests of marginalised patients in the service of questionable (utility maximising) ideals. Indeed, it will be maintained that the pursuit of popular or expedient ends must give way to a more compassionate, patient focussed ethic. The latter portion of the chapter will draw attention to the counterpoised communitarian analysis that an enduring preoccupation with individual interests is undermining the more salient collective good. It will, nevertheless, be pointed out that the desire of responsive communitarians to adopt a more equitable balance between a culture of individual rights and communal responsibilities need not be interpreted as antagonistic to the notion of legalised AVE. In fact, it is contended that this measured philosophy is sympathetic to the plight of patients and affords in principle support for reform. With these objectives in mind, the discussion will now commence with an introductory outline of utilitarian theory.

Utilitarianism

Utilitarianism is perhaps most closely associated with Jeremy Bentham and the proposal that human beings have an overriding interest in reducing their exposure to suffering (whether it be “mischief, pain, evil, or unhappiness”) and in maximising their experiences
of pleasure, happiness, and benefit.\(^1\) Bentham later took this hypothesis to its inevitable conclusion with the contention that the rectitude of any given act could be adjudged by comparing the intensity, duration, certainty, and proximity of the pleasure and/or pain produced.\(^2\) The preferred action would manifest as that which promised superior benefit or, more to the point, that which secured “the greatest happiness of the greatest number”.\(^3\) Contemporary political analysts have since characterised this controversial school of thought as “consequentialist” (in that it embraces ends that tend to minimise pain and maximise pleasure), “aggregative” (in so far as moral judgments are reduced to a calculable equation), “welfarist” (in the sense that the interests and preferences of citizens are acknowledged), and “maximising” (in the distribution of benefit).\(^4\) Today, this complex doctrine is recognised under a variety of different guises including act, rule, and preference utilitarianism. Act utilitarianism focuses upon desired ends rather than the means employed, whilst rule utilitarianism embraces the principle that a preconceived utility maximising rule should always apply under like circumstances. And lastly, preference utilitarianism suggests that the most beneficial outcome is that which satisfies the greater number of preferences.\(^5\)

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2. ibid., pp.86–87 [4:2]


A Utilitarian Response to End of life Suffering

There is ample evidence to suggest that utilitarianism exerts significant influence in the fields of contemporary bioethics and clinical practice. The scope of utilitarian thought has, nevertheless, proven sufficiently diverse that its practitioners have arrived at a variety of different conclusions on the characteristically complex issue of active euthanasia. A defining consideration in these rival utilitarian appraisals is that around 5 per cent of terminal patients cannot be adequately relieved of their pain and suffering. Indeed, the World Health Organisation’s (WHO) publication entitled *Symptom Relief in Terminal Illness* has revealed that the dying can suffer hallucinations and paranoid delusions, tremor, hyper-ventilation, weakness, a debilitating cough, depression, dyspnoea (or breathlessness), and nausea which WHO concedes is sometimes “impossible to control”. Robert G. Twycross has observed that once a patient is “mastered” by these or other equally distressing symptoms, it becomes an “overwhelming and all embracing experience”. The unfortunate reality is, however, that for “many” terminal patients

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“symptom distress” is, as Harvey Max Chochinov describes, “a defining characteristic of the dying experience”.10

Admittedly, some patients manage to turn what might otherwise be a wholly traumatic (utility diminishing) ordeal into a character building exercise. More to the point, there is credible evidence to suggest that dying patients can realise profound and enduring fulfilment in defiance of—and possibly thanks largely to—their deteriorating medical condition.11 In some cases this is manifest via a life changing spiritual epiphany, while in others the satisfaction that comes in having stoically endured this most rigorous of trials is its own reward. It also bears pointing out that these end of life ‘dividends’ can sometimes confer a benefit beyond that of the patient.12 For example, one of the world’s leading authorities on death and dying, Elisabeth Kubler-Ross, has explicitly affirmed that patients who “die with equanimity” aid those that remain to grieve with “more dignity”.13 This is an area where utilitarian theory is found wanting because it is unclear as to how it accounts for unforeseen or projected benefit, and most particularly so when that benefit only manifests after a period of utility diminishing suffering. It must still be conceded, however, that the idea of enduring the unbearable—in the hope of realising a greater good—may be too heavy a burden for some terminal patients to bear.


12 D Bonhoeffer, Ethics, edited by E Bethge, SCM Press, London, 1955, p.120

It was acknowledged in Chapter Three that the medical profession often manages the most severe forms of terminal distress via sedation.\(^\text{14}\) Needless to say that this procedure is not without drawbacks, as palliative care consultant Michael Barbato concedes that the patient’s family often derives little comfort from seeing their demoralised relative in a drug induced stupor.\(^\text{15}\) Certainly there can be no ready panacea for the additional distress caused by the patient’s physical deterioration and—sometimes dramatic—disfigurement. Having witnessed the ravages of disease in his professional capacity as a palliative care specialist, Brian Pollard concedes that shocked and overwrought relatives can suffer “sometimes as much as, or more than the patient” [emphasis added].\(^\text{16}\) Consider, for example, the experience of 81 year old US resident and leukaemia victim Helen Payne. During the last days of her life in August 1997 Helen vomited blood and was, by her carer–daughter Glenda’s own account, “restless and distressed” because “nothing could soothe her”. Glenda’s sister Dee-Dee also described her mother as being in “so much pain” that she was quite literally “moaning and groaning”. This was in spite of the fact that “everything that should have been done had been done”, Glenda later recalled. Having endured Helen’s “awful” last hours during which “dark towels” had been readied to mop up the patient’s lost blood, it was understandable that the patient and the family’s conception of managed dying as a “peaceful falling asleep” had been shattered. Indeed, it was later conceded by hospice nurse Dixie Orrison that there was “not a lot” that could be done for the patient


\(^{16}\) B Pollard, “Euthanasia – Is it the Answer?”, in, J Stuparich (ed.), *Euthanasia, Palliative and Hospice Care and the Terminally Ill*, Australian National University, 1992, p.14
during this time. The appreciable sense of despair that accompanies this kind of ‘hard death’ stands in marked contrast with the findings of a recent Netherland study which reported that the relatives of terminal (cancer) patients who opted for AVE “coped better with respect to grief symptoms and post-traumatic stress reaction than the bereaved of comparable patients who died a natural death”.

As a committed Christian, however, Helen had made it clear at the outset that she would “ride out” her illness and “not resign”. One can only speculate, if daughter Glenda—who was reportedly “immobilised by grief and loss”—might have fared better had her burdened mother been in a position to consider an AVE alternative.

The threat of having to endure an undignified and mutually burdensome dying looms so large in the minds of between 2 and 4 per cent of terminally ill citizens that they resort to (self-administered) suicide. Readily attainable yet characteristically gruesome means are employed—most typically involving poisoning, asphyxiation, or gunshot. The fact that an inordinate number of these would-be suicides ultimately prove unsuccessful in their end of life bid has prompted appreciable expressions of frustration from pro-euthanasia lobbyists


20 Wertheimer, *The Story of Helen Payne – Part Two*.


22 Quill, op.cit., p.114
who view the victim’s compounded misery as having been entirely avoidable. The act of suicide or attempted suicide can also impart a legacy of needless guilt on families who often feel personally responsible for having failed to adequately relieve the patient’s distress. Unlike the more ‘idealised’ scenario of a pre-orchestrated AVE death, bereaved family members maintain that one of the most upsetting aspects of suicide is that their loved one was completely alone when they died.

In the wake of this (needlessly) compounded suffering, some rule utilitarians have expressed opposition to euthanasia reform on grounds that the prohibition against terminating innocent life must not be contravened because it would weaken the status of an otherwise broadly beneficial (sanctity of life) maxim. This logic is exemplified in Philippa Foot’s contention that the removal of the “psychological barrier...against killing” and the inherent difficulty in devising sufficiently protective AVE legislation could leave citizens “worse off” than what they presently are. An act utilitarian (that is, one who is ends rather than means oriented) might confer that the fear and uncertainty generated by State sanctioned euthanasia, along with the potential loss and grief that a contested termination would have on the patient’s family and their immediate community, was

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excessively detrimental.\textsuperscript{28} Certainly the idea of imposing (involuntary) euthanasia on a patient who otherwise would have desired to live can also be construed as contrary to the qualifying principle that underpins preference utilitarianism.\textsuperscript{29} But this latter scenario is precisely what anti-AVE commentators fear the most. Indeed, they maintain that once competent patients are permitted to voluntarily end their life on grounds of intolerable suffering, society would invariably fall prey to the broader notion that it was equally legitimate to terminate non-consenting patients in ‘comparable’ circumstances.\textsuperscript{30} This slippery slope allegation has been met by a counter-claim that clearly defined legislative boundaries and stringent monitoring of AVE procedures would all but erase the potentiality for systemic (non-voluntary and involuntary) abuses.\textsuperscript{31} Marvin Kohl and Paul Kurtz insist that this type of carefully scrutinised voluntary euthanasia programme would, in fact, “enhance” the “general welfare” of citizens.\textsuperscript{32} In particular, it is maintained that intolerably pained terminal patients would benefit from the option of a utility maximising AVE procedure whilst broader public apprehensions about falling victim to an undignified and lingering death would also be alleviated.\textsuperscript{33}


\textsuperscript{31} Bandman, op.cit., p.93

\textsuperscript{32} M Kohl & P Kurtz, “A Plea for Beneficent Euthanasia”, in, Kohl (ed.), op.cit., p.236

Utility and Morality

While it may be tempting to embrace utilitarian logic as a means of resolving the impasse over AVE reform, this philosophy’s readiness to lure citizens to discard moral imperatives in the pursuit of sometime inequitable and unjust gains demands a more circumspect response. This is most plainly evidenced by utilitarianism’s capacity to countenance all manner of other regarding behaviour either with or without the consent of those who stand to be most impacted by it. Indeed, the imposition of majority interests or prevailing preferences upon marginalised citizens—of which terminal patients could be included—is a potentially significant flaw in the utilitarian euthanasia argument. Although utilitarians insist that they account for empathy and equity, it remains the case that these arguably indispensable ideals are always at risk of being outweighed by ‘more pressing’ utility considerations. This risk might be construed by those of a more optimistic bent as being relatively insignificant, but for those who remain sceptical about the innate goodness of human beings and the power of rational self-interest to lead us toward a more enlightened moral order, this is a debatable assumption. Certainly Jeremy Bentham’s assertion that the value laden terms ‘Ought, ought not, right and wrong’ had no meaning without reference to the principle of utility, has long been a sore point for more conservative, deontological thinkers. Indeed, utilitarianism’s alleged preoccupation with pleasure and potentially questionable preferences has ensured that it has acquired a reputation as a threat to the


36 Bentham, op.cit., p.67 [1:10]
moral status of citizens. Critics have rightly attested that this philosophy provides people with every opportunity to conduct themselves in a morally irresponsible manner by equipping them with a veritable licence to adopt extreme and/or immoral methods.\(^{37}\)

Admittedly, John Stuart Mill attempted to deflect this charge with the claim that a willingness to embrace questionable means had more to do with the participant’s character than it did with utilitarianism.\(^{38}\) Whilst there is an element of truth in Mill’s assertion, it must also be acknowledged that traditional act or rule utilitarianism is capable of countenancing immoral behaviour in the service of utility driven passions, while preference utilitarianism is no more credible given its inability to guarantee virtuous choices.\(^{39}\) It is yet to be satisfactorily demonstrated why a utilitarian should exhibit a prevailing regard for the welfare of anonymous at risk patients, when they or the majority of their likeminded cohorts stand to personally benefit (in a financial sense for instance) from ends that contravene the interests of this marginalised group.\(^{40}\)

The fact that analysts cannot categorically rule out that individual citizens will not be treated unjustly in the service of broader utility maximising ends, has prompted John Finnis to argue that a “consistent utilitarian” must concede that there are “no absolute human rights”.\(^{41}\) Consider, for instance, Joseph Fletcher’s act utilitarian assertion that

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\(^{38}\) Mill, “Utilitarianism”, p.291

\(^{39}\) Grisez & Boyle, op.cit., p.355


“relatively ‘bad’ means” may be adopted if “a morally good end” is achieved.\textsuperscript{42} The prospect of sacrificing so called “minor numbers and values” in the service of “major numbers and values” is, in fact, deemed by Fletcher and others in the secular bioethics community as a wholly legitimate and measured concession.\textsuperscript{43} This audacious claim rests on an unsubstantiated supposition that it is possible to accurately compare and trade-off otherwise incommensurable individual and collective interests.\textsuperscript{44} What might have ordinarily been construed as a fatal philosophical flaw has failed to dissuade leading ethicists such as Joseph Fletcher, Peter Singer, Helga Kuhse, and John Harris from lending their support to the notion that a patient’s status may be ‘objectively’ appraised on a sliding scale of personal and social utility.\textsuperscript{45} Whilst each of these commentators emphasises that the value of a given life should be appraised in relation to the patient’s own experience or—failing that—in accordance with expert medical testimony, it must still be said that there can be no certainty that values and expectations will be accurately interpreted or ascribed.

Reassuring claims about utilitarianism’s egalitarian ethos and its inbuilt resistance to irrational prejudices lose credibility when it is understood that its practitioners categorise some lives as being more worthy than others.\textsuperscript{46} James Rachels’s assertion that “Nobody

\textsuperscript{42} J Fletcher, “Ethics and Euthanasia”, in, DJ Horan & D Mall (eds.), \textit{Death, Dying and Euthanasia}, Aletheia Books, Frederick, 1980, p.301

\textsuperscript{43} J Fletcher, \textit{Humanhood: Essays in Biomedical Ethics}, Prometheus Books, New York, 1979, p.117. See further Smith, op.cit., p.14


really thinks that all lives are equal” is indicative of the subjectively devised personhood/humanhood doctrines—most notably popularised by the likes of Singer and Fletcher—which claim that the less complex or intuitively valuable a life is, the fewer objections one can pose against its termination. At the core of this coldly calculating doctrine is the utilitarian assumption so clearly enunciated by Singer, that it may be appropriate “to kill a person who does not choose to die on the grounds that [they] will otherwise lead a miserable life” [emphasis added]. In other instances, it is conceded that a patient’s wish to live may be traded-off in order to satisfy more compelling third-party or majority driven preferences. If nothing else, these revealing statements serve to highlight the fact that utilitarianism provides no guarantees that the right to life will be respected.

Anti-AVE lobbyists have argued that utilitarianism’s paternalistic tendencies could conceivably extend beyond the realms of the hopelessly afflicted to include the socially devalued and medically dependent poor, elderly, and the disabled. One need only pause to consider the ‘second-class’ status of financially disadvantaged (medically uninsured) US and Australian citizens who already find themselves without timely—or even satisfactory—care, to predict how this vulnerable section of the community might fare if the principle of utility and the ‘option’ of (legalised) active euthanasia were mutually


48 Singer, Practical Ethics, p.100

49 ibid., p.94 & p.99

reinforcing ideals.\textsuperscript{51} The implications are similarly disconcerting for the aged, with Janet George and Alan Davis claiming that these people are often portrayed by younger and arguably more productive citizens as “dependent and of limited value”.\textsuperscript{52} Opponents of legislative reform maintain that Western society’s “loss of any sense of the sacred” (as Margaret Somerville so aptly describes) has paved the way for the wholly unsympathetic notion that “worn-out persons” are best disposed of.\textsuperscript{53} Disabled rights advocates are also understandably disquieted by the spectre of a resource driven health system, with Not Dead Yet spokesperson Diane Coleman pointing out that the predilection of medical professionals to “assess the quality of life of disabled people” as being “dramatically lower than disabled people [do] themselves”, is well documented.\textsuperscript{54} The introduction of a utility sponsored active euthanasia programme would conceivably serve to legitimise rather than combat these discriminatory assumptions. At the very least, it could not be safely assumed that non-voluntary and involuntary active euthanasia would remain as strictly prohibited practices amidst a culture where patient consent can be overridden for expedient rather than purely just ends.

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A Looming Medical Resource Shortfall

If demographic projections are any guide, utilitarian medical appraisals may well be considered as best practice as an aging ‘baby boomer’ generation begins to absorb healthcare resources in excess of what the (diminishing) workforce is willing or perhaps able to sustain.\(^5\) In the US, demands on the medical system are expected to rise sharply with 1 out of every 5 citizens attaining the age of 65 or older by 2030.\(^6\) In Australia, the Bureau of Statistics predicts that by 2051 citizens aged 65 and over will represent about a quarter (between 24–27 per cent) of the population.\(^7\) Whilst mortality rates are set to decline throughout this extensive ‘greying’ period, the impact of the present low fertility trend in both countries will further undermine the capacity of taxpayers to shoulder the public healthcare burden.\(^8\) Apart from the anticipated delays in servicing, the (predicted) implementation of ‘unavoidable’ medical rationing could prompt the diversion of precious funding from palliative care facilities, on grounds that the allocation of scarce resources to the dying was proving detrimental to the (allegedly more pressing) recovery options of curable patients.\(^9\) Any suggestion that the community ought to be prepared to make special or ongoing utility diminishing sacrifices in order to preserve the interests of its most needy


(terminal patient) minority would, of course, risk being labelled as irrational and inadmissible by hard-line utilitarians.

In the coming decades, it is conceivable that increasing numbers of inadequately treated terminal patients may be left with little other viable pain management alternative than to seek an otherwise ‘premature’ end to their life. George, Finlay, and Jeffrey have speculated that the decision to hasten death might just as easily be taken out of the patient’s hands with “therapeutic killing” being adopted by overburdened healthcare administrators as an additional and, indeed, “legitimate consideration in [medical] resource management”. Even today there are protests from commentators including Philip Nitschke and Fiona Stewart against the so called “fiscal irresponsibility” of statutory prohibitions against “end of life choices”, and the equally ‘pragmatic’ assertions of Kuhse and Singer that it is not possible to make “infinite provision” for every life. Whilst one could speculate that the community would not permit resource driven terminations to go unchallenged, it is equally possible that frugal governments, health service financiers, and frustrated taxpayers would come to the ‘utility maximising’ conclusion that a selectively targeted active euthanasia policy served the more compelling, collective good.

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Utilitarianism and Expendable Interests

Whilst it would be imprudent to discount collective good considerations in the development of active euthanasia policy, an over-emphasis upon the communal interest and a predilection to deal with individuals as a means to an end rather than as an end in themselves is potentially detrimental to the interests of terminal patients. Take, for example, Jeremy Bentham’s claim that a true “partisan of the principle of utility” would approve or disprove of an action strictly in accordance with its potential to “augment or diminish the happiness of the community”. The implication that an individual’s regard for the communal good could reasonably extend to an act of “self-renunciation” was also endorsed by John Stuart Mill having concluded that one’s “social dignity is so important” that it could legitimately “overrule any one of the general maxims of justice”. In more recent times, Geoffrey Scarre has observed that there are “no limits on what any of us can be asked to sacrifice when public utility requires it” as it may sometimes be necessary, says Bertram and Elsie Bandman, for people to endure the injustice of “unbearable pain…for the good of others”. While it is not uncommon for choice in dying analysts, such as Nigel Biggar, to concede that people must sometimes “suffer a certain evil for the sake of preventing a greater one”, anti-AVE lobbyists, in particular, appeal to this principle in

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64 Bentham, op.cit., p.67 [1:9]


66 Scarre, op.cit., p.447. See further Bandman, op.cit., p.93
order to resist a reform that would arguably lead the entire community down a utility diminishing slippery slope.\textsuperscript{67}

**A Compassionate Alternative**

Utilitarianism’s capacity to overlook or otherwise disregard those who have *no desire* to sacrifice their legitimate interests in the service of the greater good, reminds us of this particular theory’s susceptibility to unduly paternalistic and potentially unscrupulous outcomes. Certainly a preparedness to dismiss the interests of those least able to defend themselves behoves us to shun this cost–benefit philosophy for a more compassionate ethic.\textsuperscript{68} The preferred alternative must impart justice or, more to the point, a readiness to give intolerably afflicted individuals what they deserve, whether it take the form of *adequate* pain management or *last resort* AVE. The derivatives of justice markedly contrast with the threatened amorality of utilitarianism in that fairness, liberty, and duty are consciously upheld as *indispensable* ideals. Within the context of the AVE debate, justice would take the form of a beneficent and inclusive ethos or one that takes seriously the (Biblical) admonition that “we who are strong, ought to bear the weaknesses of those without strength and not just to please ourselves”.\textsuperscript{69} Indeed, a commitment to prevent and remove harms that might otherwise befall vulnerable others is central to the concept of beneficence.\textsuperscript{70} If we can agree that Beauchamp and Childress’s interpretation of the self-

\begin{footnotes}


\item[69] Romans, 15:1

\item[70] Mappes & Zembaty, op.cit., p.19
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same ideal as representing a “duty to help others further their important and legitimate interests” is equally amenable, then one could reasonably contend that the implementation of compassion driven active voluntary euthanasia is beneficence in action.⁷¹

**A Communitarian Rebuttal of Liberal Individualism**

In light of a preference for a compassionate rather than potentially ruthless utilitarian patient management regime, the final portion of this chapter will explore the issue of euthanasia from the largely neglected perspective of *communitarian* discourse. Unlike utilitarianism, it will be argued that communitarian philosophy is well suited to engage in the debate over AVE policy as it demonstrates a more balanced regard for community *and* individual interests. It will be further attested that communitarianism’s principal complaint about the communal good as a largely overlooked component in individual rights focussed liberal cultures, need not be construed as antagonistic to choice in dying. This claim is made in spite of the fact that communitarians share the anti-euthanasia lobby’s sense of disquiet about the predilection of (liberal) reformers who characterise the individual as largely aloof from—or existing *prior* to—their community.⁷² Indeed, Daniel Bell maintains that it is as if “the liberal valuation of [individual] choice” suggests “an image of a subject” who is entitled to “impinge his will on the world”.⁷³ The *Responsive Communitarian Platform* has sought to stimulate further dialogue on this and other matters of communal

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interest, having labelled this—arguably prevailing—individual rights credo as morally deficient because it fails to adequately account for civil society as both an individual and a collective realm.\textsuperscript{74} Indeed, the public–private spheres are deemed to be incontrovertibly linked because all our actions and our associated rights claims have the capacity to implicate others.\textsuperscript{75} Communitarians further maintain that contemporary liberalism’s emphasis upon individual autonomy and a related fixation with self interest has given birth to a disengaged citizenry that is accustomed to viewing authority and coercion as an affront to their moral status.\textsuperscript{76} It is further alleged that a preoccupation with individual rights has inspired citizens to exhibit a selective attitude toward civic duty and mutual obligation.\textsuperscript{77}

The implications of a diminishing communal ethic are potentially significant as communitarians allege that the liberty and wellbeing of citizens cannot be sustained indefinitely without an ongoing commitment to the collective good.\textsuperscript{78} In light of this claim,


\textsuperscript{77} McClay, op.cit., p.17

\textsuperscript{78} “The Responsive Communitarian Platform”, op.cit., p.xxv
the movement has lobbied for liberal communities to contemplate a rebalancing of public and private priorities. The Responsive Communitarian Platform concedes that this would require a shift in cultural mores as previously self-serving citizens would need to refocus their energies upon establishing a community of “shared values, habits and practices”.\textsuperscript{79} It is maintained that this re-augmenting of citizen sensibilities is justified, as flourishing communities are arguably reliant upon their members acknowledging their mutual interests and responsibilities.\textsuperscript{80} The private pursuit of the public good has, therefore, been interpreted by communitarians as mutually advantageous because that which serves the best interests of a responsive and well ordered community can theoretically be said to benefit each of its members.\textsuperscript{81} One need only consider that the rule of law, civil rights, and democracy are all reliant upon the integrity of the communal fabric to recognise the legitimacy of the communitarian movement’s claims.\textsuperscript{82}

It is particularly revealing that in their efforts to convince citizens to embrace duties that extend beyond their own narrowly defined interests, communitarians have fallen prey to accusations of paternal moralising. Analysts including Marc J. Roberts and Michael R. Reich have, for example, questioned at what point the communitarian movement’s desire to promote community values becomes repressive or coercive.\textsuperscript{83} While there can be no

\textsuperscript{79} ibid., p.xxxvi & p.xxvi


\textsuperscript{81} RN Bellah et al, Habits of the Heart – Individualism and Commitment in American Life, University of California Press, Berkeley, 1985, p.163

\textsuperscript{82} Selznick, “Foundations of Communitarian Liberalism”, p.3

\textsuperscript{83} Roberts & Reich, op.cit., p.1057
denying that a preference for collective conventionalism and a desire to reign in excessive individualism are prominent themes in their good society agenda, communitarians have counter-argued that authoritarian allegations are unwarranted.\textsuperscript{84} The evidence at hand suggests that communitarian doctrine is, as its advocates maintain, distinctly opposed to the imposition of unduly restrictive communal demands upon contrary-minded citizens.\textsuperscript{85} The fact that communitarians remain dedicated to a policy of \textit{encouraging} rather than coercing members of the community to embrace an ‘other regarding’ perspective not only corroborates this assertion, but also reveals the movement’s hankering to cultivate what Benjamin R. Barber describes as “responsible and autonomous” citizens.\textsuperscript{86} Consider, for example, the \textit{Responsive Communitarian Platform}’s pledge to “safeguard a zone within which individuals [can] define their own lives through free exchange and choice”.\textsuperscript{87} Whilst this commitment does not preclude measured external oversight in the service of the public welfare, communitarians point out that any such proviso reflects a judicious rather than an authoritarian inclination.\textsuperscript{88} Certainly this expression of support for paternal oversight is by no means a uniquely communitarian objective, as \textit{all} ‘free’ societies acknowledge the prerogative to place (credible) limits on citizen behaviour.


\textsuperscript{87} “The Responsive Communitarian Platform”, op.cit., p.xxxiv

\textsuperscript{88} ibid., p.xxv. See further A Etzioni, \textit{The Limits of Privacy}, (Basic Books, New York, 1999) p.198
Communitarians have argued that the task of delineating the bounds of individual expression, or even of defining what constitutes the public good, cannot be properly assessed under a framework of moral neutrality. In response to this liberalism inspired predicament, leading communitarian commentator Amitai Etzioni has suggested that a process of moral reconstruction (involving the grafting of communitarian principles onto a deficient liberal order) would provide citizens with a clearer and more decisive ethical foundation. Under the influence of this hybrid doctrine, it is anticipated that a re-educated public would not only exhibit a greater regard for the communal good but would also consciously seek to redefine their individual interests to fit within the reasonable bounds of community tolerance. It should not be assumed, however, that because communitarians maintain that individual rights must be tempered by communal concerns that they are ultimately ambivalent about citizen entitlements. For example, William A. Galston has asserted that the movement has no desire to “retract or weaken a regime of rights” but rather, wishes to establish a framework that will effectively “strengthen and sustain” legitimate claims. The consensus amongst Galston and other prominent communitarians (such as Etzioni, Bellah, and Selznick) is one of striving for a more equitable—and broadly


90 ibid., p.359. See further Etzioni & Marks, op.cit., p.55


92 Etzioni, The Spirit of Community, p.249

beneficial—balance between personal liberty and communal responsibilities. It is this equality of emphasis upon public and private interests which is precisely what makes communitarianism a worthy (although largely absent) contributor to the debate over AVE policy.

A Communitarian Response to Active Voluntary Euthanasia

Palliative Care Australia’s depiction of end of life care and terminal illness as “a whole of community issue” has particular resonance for communitarians. A communitarian might, for example, argue that it is not in the broader community interest for laws prohibiting the termination of (innocent) citizens to be diluted. Philip Selznick’s warning that communitarianism “is not mainly about sympathy or benevolence” and that advocates must be careful “not [to] confuse responsibility with compassion”, is arguably tailored to this anti-AVE interpretation. Etzioni’s more specific expression of concern over reports from the Netherlands which indicate that “when active euthanasia becomes the rule, physicians often decide…to terminate patients without consulting anyone”, is demonstrative of this cautious rather than sentimental logic. Suffice to say that any such autocratic behaviour is in contravention of the core communitarian (healthcare) pledge to

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ensure that medical professionals remain publicly accountable.\textsuperscript{99} If an acceptable level of accountability can be assured, however, it is conceivable that communitarians would not stand in the way of meticulously scrutinised AVE reform.

Whilst the \textit{Responsive Communitarian Platform} offers no comment on AVE, it does make the point that the potential \textit{long-term implications} of all policy decisions must be carefully assessed.\textsuperscript{100} One should not be too hasty to read into this undertaking any reluctance on the part of communitarians to embrace legislative reform, however. Quite the contrary, as Etzioni has acknowledged that any invitation to moral dialogue may result in “extensive (although never universal) changes in the values endorsed and upheld by members of society”.\textsuperscript{101} This preference for a consultative policy process is plainly intended to ensure that discontented citizens have every opportunity to redress unsatisfactory legislation in the service of what Selznick describes as “more comprehensive interests”.\textsuperscript{102} In turn, governments are portrayed as having a reciprocal obligation to remain open and responsive to public petitions.\textsuperscript{103} Toward that end, Etzioni has suggested that legislation (and that could well include AVE reform) should typically be enacted when a 70—or more—per cent

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\bibitem{Etzi1} “The Responsive Communitarian Platform”, op.cit., p.xxv


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citizen majority endorses it.\footnote{104} The sole proviso is one that most rational and conscientious citizens would submit to, and that is that the desired reform must not be construed as detrimental to the community interest.

Although it is understood that citizens are capable of making judicious choices, communitarians are under no illusion that popular consensus always reflects a discerning or just view. The potential for all manner of questionable activities (including non-voluntary and involuntary active euthanasia) to be ‘legitimised’ by collective fiat implies that communities must remain subject to what Etzioni describes as a system of “critical moral accounting”\footnote{105}. This commitment to scrutinise public sentiment is echoed in the Responsive Communitarian Platform’s assertion that adherents are “not majoritarians” and yet, such assurances have failed to allay the concerns of civil libertarians that minority rights might be neglected or otherwise eroded under communitarian auspices.\footnote{106} It has, for example, been suggested that the responsibility for pain management (in a post-legalised AVE society) could shift from the (medical) community squarely onto the shoulders of the patient. Critics have further speculated that caregivers may lack the motivation to provide optimum palliation to patients who prefer a non-hastened ‘natural’ death, on grounds that they had irresponsibly resisted the more altruistic and efficient ‘solution’ of AVE.\footnote{107} The communitarian movement has (indirectly) responded to these concerns by reassuring their critics that discriminatory dictates would not be tolerated on grounds that all citizens have

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\footnote{105} Etzioni, “Survey Article”, p.369

\footnote{106} “The Responsive Communitarian Platform”, op.cit., p.xxvi. See further Walker, op.cit., p.179

\footnote{107} Emanuel, \textit{Whose Right to Die?}}
intrinsic worth and are entitled to be dealt with an equitable manner.\textsuperscript{108} It has been made equally clear that members of the community have a responsibility to ensure that their fellow citizens are treated in a dignified and humane fashion and that the vulnerable, in particular, are actively protected from \textit{avoidable adversities}.\textsuperscript{109} These undertakings are, for want of a better interpretation, wholly conducive to the idea of strictly monitored beneficent AVE.

Whilst the Communitarian Platform has emphasised “caring, sharing and being our brother’s and sister’s keeper” as an “essential” attribute of the good society, it is not intended that this altruistic credo be taken to an extreme.\textsuperscript{110} For instance, the \textit{Responsive Communitarian Platform} alludes only to an attitude of constant “self-awareness” rather than that of “heroic self-sacrifice” in sustaining the “material and moral wellbeing of others”.\textsuperscript{111} This \textit{measured response} sits comfortably with the mainstream pro-AVE lobby’s desire to quench the intolerable pain and suffering of terminal patients \textit{without} placing other citizens at an \textit{unacceptable risk}. It also does not exclude, however, the communitarian movement’s clearly elucidated commitment to provide the basic healthcare entitlements that citizens might reasonably require.\textsuperscript{112} This assurance goes to the very heart of communitarian doctrine as Etzioni has asserted that “assum[ing] responsibility for

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\textsuperscript{110} “The Responsive Communitarian Platform”, op.cit., p.xxx
\textsuperscript{111} ibid., p.xxxiv
\textsuperscript{112} A Etzioni, “End Game – What the Elderly have Earned”, \textit{The American Scholar}, Spring 2005, p.37. See further Cassel \textit{et al}, op.cit.
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others”—and that necessarily includes the most dependent of terminally ill citizens—remains as “the core tenet of the good society”.\textsuperscript{113}

The fact that communitarians are dedicated to establishing circumspect yet supportive and responsive communities should be a source of comfort both for those who favour the legal option of AVE, and for anyone else who fears the imposition of arbitrary active euthanasia practices. The communitarian pledge to ensure that citizen choices are ‘authentic’ (rather than consciously or unconsciously imposed) arguably reinforces the credibility of this claim.\textsuperscript{114} Admittedly, there is a potential risk that this premise may be undermined if the patient’s desire to end their life is a symptom of an alienating or unsupportive social framework.\textsuperscript{115} This may be particularly apparent in liberal communities where the requirements of “social dignity” (including personal independence, “prestige” and “composure”) are highly valued without sufficient regard for the individual’s need to be integrated and supported by “the greater whole”.\textsuperscript{116} Indeed, it has been suggested by Margaret Somerville that the resultant “loss of community” that a number of (terminal) citizens experience could well be “a causal factor in the emergence of the euthanasia [reform] debate”.\textsuperscript{117} The “lonely” and “dehumanised” process of modern dying has been more fully explored by Elisabeth Kubler-Ross who expressed concern that patients are

\textsuperscript{113} Etzioni, \textit{Next}, p.29
\textsuperscript{114} RE Goodin, “Permissible Paternalism”, in, Etzioni (ed.), op.cit., p.121
\textsuperscript{117} ibid., p.125
sometimes made to feel like a mere “thing” rather than a uniquely invaluable human being. This sense of helplessness and marginalisation certainly goes some way in explaining why euthanasia candidates sometimes express a fear of dependency as being more onerous than even death itself. Indeed, the indignity of no longer being able to be an active participant in community life—or even to care for one’s own bodily needs—in a culture where independence is incontrovertibly linked to self-esteem, can arouse feelings of inadequacy and a sense of unworthiness amongst some patients. It bears emphasis that this reaction is as much a community concern as it is an individual one, as Mark G. Kuczewski has pointed out that “values do not simply emanate from some ineffable core within us but take shape through interaction with our environment”. This is just one area in which communitarianism can make a potentially invaluable contribution to the end of life debate, as the movement’s emphasis upon greater connectiveness and mutual regard could conceivably help reduce the number of patients whose desire for AVE was socially inspired.

The suggestion that patients are sometimes motivated to seek death in response to communal pressures is clearly at odds with the communitarian ideal of a supportive social network. Indeed, the Communitarian Network’s *Position Paper on Healthcare Reform* maintains that the provision of universal “comfort” care and “palliation” is the basis of “compassion”. Toward that end, it is argued that the community must be prepared to “sustain” the medical system so that these “humane” objectives can be consistently

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118 Kubler-Ross, op.cit., pp.7–8

119 Quill, op.cit., p.105 & p.116

upheld. The position paper further affirms that medical professionals “are expected to put their patients *ahead of their own self-interest*” and to “*respect patient values*” [emphasis added]. Whilst there is *no* suggestion that physicians should be compelled to participate in an AVE procedure, communitarians do maintain that they have a particular duty to ameliorate human suffering “*whenever possible*” [emphasis added]. In addition to this undertaking, “futile attempts or curative therapy of life extension beyond a point of meaningful participation” are to be consciously avoided. Under circumstances where the interests of patients, families, and physicians are adequately accounted for, Etzioni maintains that there should also be an option to “end life when suffering becomes unbearable”. This expression of support for last resort AVE is a reflection of the *compassionate* value system which arguably underpins communitarianism’s responsive yet conscientious patient management policy.

**Conclusion**

This chapter initially argued that doctrinally flawed utilitarianism could not be relied upon to safely dictate the parameters of active euthanasia practices. Whilst it was acknowledged that utilitarians are capable of embracing moral ends, it was clear that there could be no guarantees that ‘more persuasive’ utility maximising options would not sway their collective resolve. Indeed, it was alleged that utilitarianism’s means to an end mentality could prompt irresponsible majorities to embrace virtually *any* utility maximising

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121 Cassel *et al*, op.cit.

122 ibid.

123 ibid.

behaviour. Despite the potential *utility diminishing* implications (including the sanctioning of non-voluntary and involuntary active euthanasia) that utilitarianism could pose for *marginalised citizens*, it was pointed out that influential bioethicists continue to advocate active euthanasia terminations upon individuals with perceived low quality of life (utility) ratings. A willingness to overlook the impracticality of allocating an objective *and* precise value for any one life over that of another did, nevertheless, undermine the credibility of utility based appraisals. It was duly concluded that a more accommodating or sympathetic approach to patient management remains preferable to that provided under the coldly calculating auspices of utilitarian reasoning.

The latter portion of the chapter took up a possible communitarian response to euthanasia reform with its commitment to the collective *and* individual interest touted as a credible counter-balance to utilitarianism’s penchant for majoritarianism and liberalism’s prevailing preoccupation with individualism. Whilst critics have responded by expressing concern about communitarianism’s call for a rebalancing of public and private priorities and its arguably narrow rights and responsibilities ‘good society’ agenda, allegations about paternal authoritarianism were rejected on grounds that a commitment to uphold the public welfare is a prerogative which is exercised in all ‘free’ societies. Moreover, the communitarian pledge to ensure that *all* people are treated in a fair and compassionate manner gave rise to the conclusion that communitarianism is sufficiently tolerant to accommodate choice in dying, without compromising its underlying commitment to moral accountability and the collective good. It is somewhat ironic, therefore, that this important yet largely neglected communitarian contribution to the euthanasia debate highlighted a number of moral ideals that are shared by the Church and yet, the mainstream clergy remains contrastingly opposed to AVE reform. While the chapter to follow will explore
this issue further, particular emphasis will be placed upon associated arguments about the legitimacy of the Church’s involvement in this so called secular policy issue.
6 EUTHANASIA, THE CHURCH AND SECULAR POLITICS

Introduction

Conservative religious groups, in particular, have sought to defend the traditional sanctity of life principle by voicing their opposition to the allegedly immoral and risk laden objective of legalised active voluntary euthanasia (AVE). Advocates of Church–State separation have, nevertheless, rejected this attempt on the part of the religious community to impose a faith-based agenda in favour of an enforced temporal–spiritual divide in ‘secular’ political affairs. This discussion will reveal the principle motivations underlying these two competing schools of thought by exploring the historic roots of the divine right thesis and Enlightenment (liberal) counter-claims, before moving on to investigate United States (US) and Australian separation of Church and State constitutional provisions. Although it will be later argued that the Terri Schiavo affair and the Rights of the Terminally Ill Act disallowance exposed politicians as being ready to accede to unrepresentative religious convictions and/or lobby group pressure, attempts to exclude religious input in policy formulation will, nevertheless, be characterised as a violation of liberal–democratic ideals. In expressing a preference for a rational religious contribution in the right to die debate, it will be contended that the mechanism of a democratically established reform mandate is a preferable alternative to a policy of political exclusion.

Religious Responses to Active Voluntary Euthanasia

Attempts by advocates of legalised AVE to win over their more conservative pro-life opponents have often been hindered by the absolutist moral convictions of orthodox religious lobbyists. Indeed, the practice of assisted dying has characteristically been met by expressions of disapproval from the world’s major religions with mainline Christian
groups, in particular, having officially resolved that the timing of death is God’s prerogative alone. While Protestant and Catholic clergy concede that an unhelpful prolongation of life is to be avoided, they maintain that it is possible to minister to the needs of the terminally ill without reverting to the arguably presumptive and immoral practice of active euthanasia. This traditional interpretation is informed by an orthodox Judaic teaching which forbids the termination of life (or that which is purportedly made in the image of God) in order to escape pain and suffering. Diverging views on the legitimacy of last resort AVE do, nevertheless, exist amongst progressive Judaism and amongst significant numbers of Protestant and Catholic Church and non-Church goers who support conscientious choice at the end of life. In contrast, Islamists maintain a strict consensus that mercy killing is forbidden under any circumstances because it violates Allah’s divine sovereignty. A somewhat more complex perspective is assumed by Buddhists who argue that the wilful termination of one’s life disrupts the natural order and thereby creates

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spiritual regression on the path to enlightenment. Although Buddhists admit that a voluntary death may be permissible on altruistic grounds, those who undertake AVE in response to selfish ambition and/or fear are thought to have committed the offence of self harm, with the manner in which a person departs this life having a profound and potentially detrimental impact upon the life to come. While some have seen fit to refute claims that harm is inflicted by last resort AVE, the prevailing Hindu view is that the violation of the natural dying process inflicts damage both to the patient and their accomplice’s spiritual fate or ‘karma’. In light of the consistency of this and other orthodox religious opposition to choice in dying, this discussion will focus entirely upon one particular tradition and its broadly representative response to euthanasia reform. While not wishing to overlook the fact that pluralistic Western society accommodates all of the religious cultures alluded to here, this discussion’s focus upon Christianity is indicative of the fact that the Church has played a defining role in the moral and political frameworks of nations such as the United States and Australia. With these thoughts in mind it is appropriate to explore how the Church came to hold such an influential position in the affairs of State.

The Divine Right Thesis and the Separation of Church and State

Following Emperor Constantine’s personal conversion and subsequent exoneration of the once ruthlessly persecuted Christian faith as the religion of empire in the 4th Century, it was assumed that the Church’s influence would naturally extend beyond the ecclesiastical


realm to that of ‘temporal’ administrative affairs. More to the point, the scriptural assertion that *all authority* is established by God was seen as providing legitimacy for the head of state to assert a *divine right* in exercising political power over their subjects. In the execution of this divinely ordained overseer role, the sovereign was characterised as being accountable to God alone in preserving the good by acting as an “agent of wrath” against “wrongdoers”, while the people had a reciprocal obligation to submit to their appointed ruler as they would to God Himself. It was seemingly inevitable, therefore, that latter-day enlightened scepticism regarding the alleged inerrancy and truth of the Judeo-Christian scriptures would contribute to the undoing of this divine right thesis. Radicalisation from within the Church itself provided additional impetus to this cultural shift, as the Protestant movement’s hard won victory over scriptural accessibility and an individualised relationship with God laid the groundwork for related claims that citizens’ spiritual emancipation should rightfully extend to a self-prescribed relationship with their temporal overseers. Toward that end, the once prevailing ideal of hereditary succession was exchanged for the more equitable democratic practices of public election and

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representative governance. This commitment to freedom of conscience had additional implications for the Church as John Locke’s argument that State administrators must be absolved of having to comply with divisive faith based dictates that were “beyond the discovery” of “natural faculties and above reason” plainly attested. Locke along with fellow liberal commentator, Thomas Hobbes, specified further that the chief role of temporal administrators was to ensure the peace, order, and safety of the citizens placed under their charge, while it was the clergy’s unique and decidedly separate duty to foster spirituality and the salvation of souls.

The US Constitution and Freedom of Religion

It is readily apparent that the United States’ Founding Fathers were profoundly influenced by liberal thought, with the Lockian analysis of “the Church...[as] a thing absolutely separate and distinct from the Commonwealth” giving rise to a view that “The boundaries on both sides” of the secular and sacred realm must remain “fixed and immovable”. Having been made acutely aware of Europe’s experience of bloody sectarian persecution and conflict, the Founders recognised that there was a need to ensure that the State was prohibited from imposing one view of Christianity on other Christians and likewise, that

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15 Locke, “A Letter Concerning Toleration”, p.403
the State was protected from the polarising dogmatism of the Church.\textsuperscript{16} As it happened, schisms had already been manifest amongst the fledgling nation’s various colonies with Puritan elements, for example, enlisting State authority to exact retribution (including imprisonment and capital punishment) upon dissenting Baptists and Quakers.\textsuperscript{17} In choosing to adopt a compromise ‘universal’ deist position, the Founding Fathers hoped to overcome further theological conflict or equally divisive allegations of sectarian favouritism.\textsuperscript{18} The US Constitution’s First Amendment clause was, thus, specifically designed to protect freedom of conscience and diversity of religious belief by stipulating that “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof”.\textsuperscript{19}

Despite the fact that the phrase “separation of Church and State” was not mentioned in the Constitution, Thomas Jefferson later confirmed that the First Amendment’s implicit purpose was to build “a wall of separation” between the two institutions.\textsuperscript{20} In more recent times, the US Supreme Court has upheld this ideal, having expressly asserted in \textit{Everson v. Board of Education} (1947) that the wall between Church and State “must be kept high and

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\bibitem{17} Berg, op.cit., p.43
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impregnable”. While some have interpreted this establishment clause as implying a comprehensive repudiation of religious interference in secular policy affairs, others like Samuel Huntington and William McLoughlin maintain that it is more accurate to conclude that the First Amendment was never intended to ensure “freedom from religion but rather, freedom for religion”. While there is no question that the framers were dedicated to ensuring that the State remained religiously neutral, one need only consult The Declaration of Independence and its various references to the Creator God and “Divine Providence” to recognise that they were certainly not hostile to religion. In taking steps to ensure that the State would have no part in the redemption of humanity or in the interpretation of religious moral law, it remains feasible that the predominantly Christian Founding Fathers envisaged that the Republican Government would itself be influenced by religious values. Indeed, the Fathers’ implicit assumption was that the Church would participate in political life by fulfilling a role that the State was ill equipped to do—namely, the nurturing of a moral citizenry.


24 Huntington, op.cit., p.84 & p.106

Christian Activism in Contemporary US Politics

In keeping with the Founding Fathers’ prophetic vision, the Church today continues to exert influence amidst what is an overwhelmingly religious citizenry, with Christians well represented amongst the major political parties, on local councils, and in lobby groups. In the latter case, social analyst Robert Putnam has described the nation’s thriving evangelical community, in particular, as the “largest, best organised grassroots social movement of the last quarter century”. Putnam’s claim was certainly vindicated after the evangelical Church mobilised tens of millions of voters into a formidable political force in the 2004—‘moral values’—US Presidential election. While these Christian voters provided crucial support to the conservative Bush Republican Party, this result came as no particular surprise to those commentators who recognised that the ‘born-again’ George W. Bush was a President who appeared to share a number of fundamental Christian beliefs. Suffice to say that the President’s support for “a culture of life”, habit of portraying political and...


27 RD Putnam, Bowling Alone – The Collapse and Revival of American Community, Simon and Schuster, New York, 2000, p.162. It bears emphasis that the rise of the religious right is motivated, in part, by a perception that secular liberal philosophy is antagonistic to traditional moral values. Elements from within the Christian right have responded to this perceived problem on a defensive level—in the sense that they typically lobby to preserve longstanding conservative moral ideals—and on a pro-active level in their efforts to convince others about “ultimate truth”. An insightful discussion on the Christian right is available in: M Durham, The Christian Right, the Far Right, and the Boundaries of American Conservatism, Manchester University Press, Manchester, 2000, pp.105–109. See further WA Galston, “Public Morality and Religion in the Liberal State”, P5, Vol.19, No.4, Autumn 1986, p.818

moral issues in absolutist terms of ‘good and evil’, and his willingness to lend an ear to conservative Christian leaders ultimately won over 78 per cent of evangelical (Protestant) voters and some 72 per cent of traditionalist Catholics. While the President has since conceded that “it’s important to maintain the separation of Church and State”, he has been equally candid in expressing support for the Church’s “vital role” in the promotion of “high moral standards” and in helping to shape a citizenry that is dedicated to ensuring that the nation fulfils its “great duties” under God. The White House’s controversial decision to incorporate religious bodies in the administration of public affairs (i.e. through its Faith Based Community Initiatives in which religious groups are provided with Federal funding to fulfil non-proselytising social services) and its antagonism toward ‘progressive’ policies (on abortion, stem cell research, and gay marriage) has, nevertheless, fuelled scepticism amongst more liberal religious and secular citizens in relation to the Administration’s level of commitment to Church–State separation. Indeed, it has been argued that conservative Christians have exerted a disproportionate influence upon the Administration, with the


President himself viewed as being unduly swayed by right-wing religious lobbyists who are often depicted as antagonistic to the separation principle.\textsuperscript{32}

\textbf{The Terri Schiavo Intervention}

Confirmation of Washington’s religious sensitivity was particularly evident after Federal authorities succumbed to conservative Christian—and pro-life—lobby group pressure in seeking to preserve persistent vegetative state (PVS) patient Terri Schiavo’s life sustaining feeding tube.\textsuperscript{33} While the Administration’s critics viewed this initiative as being primarily influenced by religious sanctity of life convictions there were, nevertheless, a number of practical concerns raised regarding the reliability of Schiavo’s alleged medical preference testimony and questions about conflicting medical diagnoses.\textsuperscript{34} These concerns were, thus, touted as the inspiration for the US Congress and President Bush to join forces in taking the unusual step of implementing legislation requiring a Federal Court review of the case.\textsuperscript{35}

In spite of the fact that this extraordinary measure ignored previous Court rulings to remove the feeding tube and thus contravened the patient’s express wish to be allowed to die if ever subjected to a hopeless vegetative state, Schiavo’s devout Catholic parents had personally petitioned for Congressional action in light of a Papal edict that hospitals were


\textsuperscript{35} “President George W. Bush’s Statement on S.686”, in, Caplan, McCartney & Sisti (eds.), op.cit., p.152
“morally obligated” to provide “basic care” to PVS patients. Washington’s sympathetic response naturally drew plaudits from a variety of other conservative Christian sources, with Focus on the Family’s James Dobson commending this Federal initiative as an “act of mercy”, while the Family Research Council maintained that the Schiavo Bill had brought Capitol Hill’s “good people” to the forefront of public attention. While President Bush also expressed his appreciation for this bi-partisan supported intervention, the New York Times Maureen Dowd was wont to question if an “emasculated” Democratic Party and their “obsessed” Republican counterparts were intent on turning the nation into “a wholly owned subsidiary of the Church”. The Congressional record had undoubtedly fuelled the concerns of Dowd and other commentators, as all but five participating House Republicans supported the Schiavo intervention, giving rise to allegations that the influential religious right and its Congressional sympathisers had little regard for the secular separation of Church and State principle.

The Federal Government’s subsequent Judicial rebuke on grounds of a separation of powers violation was viewed by its many critics as a timely lesson that politics and so


called “State endorsed religion” had no place in the private affairs of citizens.\textsuperscript{40} There was substantial public support for this perspective with 39 per cent of Americans expressing the view that conservative Christian lobbyists had exerted undue influence over the Bush Administration and that in spite of evidence that 82 per cent of poll respondents (and a further 51 per cent majority of weekly Church-goers) had endorsed Schiavo’s feeding tube being removed.\textsuperscript{41} While one need not have agreed with those more conservative Christians who advocated Federal intervention, it bears emphasis that all law abiding citizens are entitled to pursue their self prescribed political interests in a liberal–democratic society. Politicians must also have some discretionary authority which may, in circumstances of public misinformation or ignorance, be exercised in contravention of the popular will. Admittedly, in this particular instance there was no compelling reason to assume that the Judiciary or the public had got it completely wrong and yet, it is perhaps understandable that the distinctly other regarding decision to remove an incompetent patient’s feeding tube inspired a heightened sense of moral accountability. The problem was, however, that in seeking to ensure that Schiavo’s right to life had been adequately protected Congress ignored the patient’s reportedly express wish to be let die. Although religious considerations appear to have been a distinguishing factor in this intervention, the issue was not how this decision was arrived at but rather, that politicians of both religious and non-religious persuasions capitulated to an unduly paternal minority. While this outcome appears to have been motivated by ideological conviction and/or political self interest, the difficulty of finding a balance between political representation and measured religious

\textsuperscript{40} “The Schiavo Hypocrites”, \textit{Nation}, Vol.280, No.14, 11 April 2005, p.5. Please note that the judicial process will be explored in Chapter Seven.

expression is not unique to the US, as Australian politicians have also had to grapple with this complex issue.

The Australian Constitution and Freedom of Religion

The idea that religious liberty is an inalienable right is in keeping with the Australian constitutional framers’ assumption that citizen endorsed politicians would express their religiosity in policy affairs.\(^{42}\) It was only fitting, therefore, that the framers would look to their US predecessor in drafting Section 116 of the Australian Constitution which states that:

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The Commonwealth shall not make any law for establishing any religion, or for imposing any religious observance, or for prohibiting the free exercise of any religion, and no religious test shall be required as a qualification for any office or public trust under the Commonwealth.\(^ {43}\)
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This clause reflects a belief that administrative power should be restricted in an area of life that the State has no insight or authority to involve itself, whilst still ensuring that freely prescribed religious practices do not violate the legitimate rights of non-aligned citizens.\(^ {44}\) Some contemporary advocates of the separation of the Church and State have,

\(^{42}\) M Maddox, *For God and Country – Religious Dynamics in Australian Federal Politics*, Department of the Parliamentary Library, Canberra, 2001, p.132


subsequently, deduced that while politicians may be influenced by their private religious convictions, they are duty bound to rationalise policy on strictly non-religious grounds.  

**Christian Political Activism in Australia**

Arguments in favour of secular reason appear increasingly compelling in light of the fact that the Church’s status within the Australian community has diminished. While mainline Christian congregations suffer from ever declining numbers, the Christian Research Association of Australia reports that the contrastingly prosperous evangelical community (comprising Pentecostal and more conservative elements from within Catholic, Baptist, Lutheran, and Anglican parishes) has managed to buck the national trend. More importantly, the capacity of this conservative constituency to make themselves known in ‘secular’ politics was demonstrated in the 2004 Federal election, with the newly formed (Pentecostal backed) Family First Party’s pledge to uphold “Christian ethics” attracting around 2 per cent of voter support. Although this was a modest result, it is noteworthy that the conservative Howard Government (which has typically attracted the majority of the Church-going vote) ultimately relied upon Family First preferences in its quest to win

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important marginal seats. There is little doubt that this alliance had been made possible thanks in part to the Federal Government’s willingness to court so called aspirational (evangelical) voter preferences for a traditional moral values policy agenda.

Apprehensions about the moral decline of (secular) society had clearly helped galvanise elements from within the conservative Christian community to place their support behind representatives that appeared ready to defend the nation’s historic and arguably threatened links with Judeo-Christian tradition. Senior Government officials, both then and since the 2004 election, have not discouraged this sense of unease with Foreign Affairs Minister Alexander Downer’s (LIB) statement about a “post-Christian age” and Treasurer Peter Costello’s (LIB) subsequent illusions to “moral decay” serving to confirm conservative religious fears. In more recent times, Prime Minister John Howard (LIB) has expressly appealed to this constituency by arguing that there is a need for policies that would “help to reinforce social norms and values” that are purportedly “under assault in various ways”. While the Prime Minister insists that Australia is “not a nation that mandates a particular faith”, there is little question as to where he would prefer to draw the bulk of support for


53 B Hurrell, “Social Values under Assault”, *Advertiser*, 5 May 2006, p.4
this revitalised moral vision, having publicly endorsed Christianity as “the single greatest influence for good in the Australian community”.\textsuperscript{54} Certainly there is sympathy amongst Howard’s colleagues on the social benefits of a religious moral perspective, as it has been observed that the Government’s most senior members have been more active than any previous federal government in publicly enunciating their spiritual convictions.\textsuperscript{35}

**The Federal ROTTIA Intervention**

The Howard Government took the opportunity early on in its Administration to demonstrate its conservative credentials when it successfully moved in 1997 to disallow the parliamentary endorsed Northern Territory *Rights of the Terminally Ill Act* (1995). Needless to say that this bi-partisan (Liberal–National [Coalition] and opposition Labor Party) supported Federal intervention gave rise to inevitable questions about the impartiality of Christian politicians and the legitimacy of pressure exerted upon them and other Commonwealth MPs by religious groups.\textsuperscript{56} Indeed, the pre-eminent National Council of Churches had previously made it plain to the Commonwealth Senate Legal and Constitutional Legislation Committee (on the *ROTTIA*) that active euthanasia is “contrary to God’s law and the values of a civilised society”.\textsuperscript{57} It turned out that the Prime Minister’s


\textsuperscript{55} Warhurst, “Religion and Politics”, p.23


perspective was principally in keeping with this view, having advised the House that he held “the strongest possible reservations” about the Territory initiated *ROTTIA*.\(^{58}\) Howard’s belief that “respect for human life” must be preserved as a moral “absolute” ultimately prompted him to invite fellow MPs to exercise their right to introduce a Private Member’s Bill in opposition to the Territory law.\(^{59}\) The readiness of ultra-conservative Liberal backbencher Kevin Andrews (LIB) to implement this motion immediately gave rise to allegations that Christian members of the Government (and most particularly, those affiliated with the right-wing Lyons Forum) were conspiring to impose a religious ideological conviction upon a contrary-minded community. The suggestion that the Lyons Forum had played a pivotal role in the subsequent *Euthanasia Laws Act* was later refuted by Kevin Andrews, having maintained that the Government’s decision to disallow the Territory’s world first legislation would not have “got to first base” if it had been reliant upon the influence of “some narrow group”.\(^{60}\)

The political clout of the Lyon’s Forum could not be so easily discounted, however, as it reportedly incorporated a fraternity of around 50 members including the Prime Minister (LIB), the National Party Deputy Prime Minister Tim Fischer (NAT), Treasurer Peter Costello (LIB), and Foreign Affairs Minister Alexander Downer (LIB).\(^{61}\) Whilst this


\(^{61}\) ibid.
influential group’s Christian affiliation remained officially “ambiguous”, Marion Maddox has observed that the “Forum’s statements and the comments [of] its spokespeople” were “rich in language long identified with the American religious right”. The fact that there was little attempt on the part of the membership to rectify media descriptions of the group as an “ultra-conservative Christian faction” appeared to further vindicate claims about the Forum’s distinctly religious identity. Although at least one member of the Government has argued that the Forum is “non-religious”, only a handful of others have been prepared to openly concede that the group’s orientation is distinctly Christian. Confirmation of the Forum’s ideological leanings would, however, have been largely redundant as it was clear that the ideas being generated at the time of the ROTTIA debate from various Forum members were distinctly sympathetic to religious sensibilities.

Treasurer Peter Costello (LIB) was amongst the most candid in expressing his “religious belief” that “the dignity of life…should never be surrendered” in order to satisfy the risk laden objectives of legalised AVE and PAS. While conceding that a decision to endorse Federal intervention against these provisions may not be popular with the electorate, Neil Andrew (LIB) also made no secret of his religious (pro-life) “prejudices” against the

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62 Maddox, *God Under Howard*, p.38 & p.69


64 Maddox, *God Under Howard*, pp.66–68


practice of mercy killing. In response, the Labor Party’s Mark Latham took issue with his Liberal Party counterparts’ implicit assumption that it was acceptable to force “terminally ill people to judge life itself through the prism of someone else’s moral code”. Latham’s small ‘L’ liberal view was later endorsed by Carmen Lawrence (ALP) who, while acknowledging a “respect” for her religious colleagues, maintained that it was “simply…not relevant to invoke God’s will and God’s gift of life” in order to rationalise the reversal of democratically endorsed ‘secular’ legislation. Federal Health Minister and Lyons Forum participant Tony Abbott (LIB) defended the House of Representatives’ decision to overrule the Territory law, however, arguing that “Christian revelation was not necessary” for Andrews Bill supporters to form a compelling view that the ROTTIA wrongly “converted human beings into disposable commodities to be put down when old, useless, or in pain”. While Abbott has since admitted that it is inappropriate to expect that Government policy should be based on “religious values” he, nevertheless, concurred with the Prime Minister that there was a direct correlation between ‘religion inspired’ principles and a ‘universally’ recognised good, such as protecting innocent human life. This rationale appeared to alleviate the need for overt religious rhetoric as Marion Maddox has observed that of the 80 House of Representatives speeches on the ROTTIA, only 8

67 ibid., p.7350 [21 November]. For a similar argument see p.7343 [21 November]

68 ibid., p.7340 [21 November]

69 ibid., p.7352 [21 November]


71 T Abbott, “Church, Civil Society and Politics”, in, Sullivan & Leppert, op.cit., p.5
specifically referred to God.\textsuperscript{72} Indeed, it bears emphasis that most arguments raised in support of the Andrews Bill were focussed upon universal rather than distinctly religious contentions about patient abuse and error, the risk of financially motivated terminations, and the need to improve citizen access to palliative care services.\textsuperscript{73}

In contrast with the House of Representatives comparatively discreet religious dialogue, Maddox has observed that the Senate adopted a distinctly “theological flavour” with members routinely invoking the name of God and appealing to religious themes.\textsuperscript{74} Of these, it is noteworthy that only a small minority of Senators (who were in favour of the \textit{ROTTIA}’s disallowance) acknowledged that their abuse related concerns were supplemented by religious motivations.\textsuperscript{75} While Senator Bernard Cooney (ALP) defended the right of his Senate colleagues to oppose the \textit{ROTTIA} in light of their religious ideals, fellow Senators’ Kate Lundy (ALP) and Sue Mackay (ALP) pressed home the counter-claim that religious convictions should not be relied upon in order to enforce the disallowance of legitimately enshrined secular legislation.\textsuperscript{76} Both Lundy (ALP) and Party ally Chris Schacht (ALP) were, in fact, convinced that many of the Parliament’s right-wing Lyons Forum members had come to view the \textit{ROTTIA} debate as a prime “political


exercise” that if successful, would embolden these religious ideologues to pursue other equally invasive moral agendas.\textsuperscript{77} Lundy further alleged that this influential lobby’s “extremely conservative” philosophy was ultimately aimed at serving the interests of a “handful” of “moral crusaders” and “zealots” to the detriment of individual freedom of conscience and the broader secular community interest in social diversity.\textsuperscript{78} If this was their intention then one cannot go past Maddox’s conclusion that the relative scarcity of overt religious expressions in support of the \textit{Euthanasia Laws Bill} amongst the Senate was no less than a calculated decision.\textsuperscript{79} For example, Australian Democrats Senator John Woodley (AD) was quick to clarify that his opposition to the \textit{ROTTIA} stemmed from a “broad commitment to human rights and social justice” issues rather than in response to his association with the Church.\textsuperscript{80} While the sincerity of Woodley is not in question here, the Senate \textit{ROTTIA} disallowance debate seemed to vindicate Maddox’s claim that a number of Christian parliamentarians were indeed sensitive to the fact that placing an overt emphasis upon religious edicts would risk alienating some separation of Church and State advocates and non-religious constituents alike.\textsuperscript{81}

Concerns raised about religious influence in the \textit{ROTTIA} debate were arguably overshadowed by evidence that some Federal politicians (such as Lundy and Mackay) were inclined to argue that their colleagues should lay aside their religious convictions in

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\textsuperscript{77} ibid., p.2101 & pp.2106–2107 [20 March]
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\textsuperscript{81} Maddox, \textit{God Under Howard}, p.68
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deference to the separation principle. Needless to say that this contentious attempt to neutralise their political opposition discounted the fact that people of faith often lay great stow on their duty to advocate and defend religious ideals. More to the point, the Biblical directives that Christians are to be “the salt of the earth” and “the light of the world” are clearly not intended to be viewed as idle expressions. To suggest that this overriding spiritual obligation should be sacrificed in the interests of alleged ‘secular objectivity’ and ‘unity’ is no small thing, if only because a similar expectation is not imposed upon other equally divisive ‘non-religious’ actors who may be just as intent on pursuing their own ideologically driven policy objectives. It is clear, therefore, that any attempt to expunge religion from the political landscape in order that a more open and tolerant society might arise is by its very nature a contradiction. Moreover, the underlying assumption that the constitutional establishment clause implies absolute exclusion of religion arguably places the equally pertinent free exercise provision (which conceivably accommodates the right to assert a religious position on policy issues) at an undue disadvantage. While there is no denying that all citizens need to appreciate that freedom of religion is provided in exchange for the right of non-aligned citizens to go about their lives without being unduly imposed upon by unwelcome spiritual dogma, this live and let live principle ought not be


83 Matthew 5:13–14


undermined by assumptions that law abiding religious citizens have no corresponding right to actively pursue scripturally inspired political objectives.

Prime Minister Howard has hinted at his own concern about attempts to marginalise religion and religious voices in public debate, having lamented the “strange awkwardness” that has taken root in relation to Christianity’s “broad interaction [in Australian] public life”.  

While Howard freely concedes that the Church’s “primary role is spiritual leadership”, he also maintains that Church leaders have a “right…to talk about anything” and, in particular, to “speak out on moral issues”.  

It was clear that in the case of the ROTTIA, elements from within the Church exercised their political voices to the desired ‘moral’ effect as pro-choice lobbyist Philip Nitschke has since remarked that the Territory Act’s disallowance represented a “failure of democracy” which had come about because this unrepresentative constituency had been permitted to play a crucial role in destroying “decent legislation”.  

More specifically, Nitschke maintained that the combination of the Church’s “behind the scenes influencing of politicians” and (Catholic) Kevin Andrews’ willingness to act as a so called “errand boy for the Pope”, had prevailed over better judgment in support of Church–State separation.  

One need not support the notion of religious exclusion from policy formulation however, to appreciate that Christian


87 Warhurst, “Religion and Politics”, p.28


89 Nitschke & Stewart, op.cit., pp.97–98
Parliamentarians and lobbyists would have indeed appeared more credible if they had been prepared to enunciate their opposition to AVE whilst still respecting the democratically ascribed wishes of the Northern Territory community. As it happened, the Commonwealth’s (conscience vote) decision to disallow the ROTTIA effectively contravened the core liberal–democratic and Biblical principle of self regarding freedom of choice. Federal ROTTIA advocates were right, therefore, to remind the Andrews lobby that human beings unique relationship with God and its implications for dignity and compassion would have been best served by permitting Territory residents to explore their own conscience on AVE or PAS.⁹⁰

**Religion as a Private Affair?**

Given that it is a contradiction to suggest that people should be forced to conform to the dictates of a voluntary fraternity such as the Church, advocates of Church–State separation have consistently maintained that religion should be constrained to within the realm of personal preference and conviction.⁹¹ On the face of it, this viewpoint seems entirely reasonable as it is possible for people to reject a spiritual pronouncement in their own lives without imposing a tangible injury upon those who hold this particular directive as sacrosanct.⁹² Moreover, liberal theorist John Stuart Mill famously argued that in allowing citizens to draw their own conclusions on religious matters, society would tend to avoid falling victim to the “grave practical evil” of “narrow” religious doctrine being viewed as

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⁹² Locke, “A Letter Concerning Toleration”, p.400 & p.410
the “complete rule” for human guidance. Although keen to emphasise that he was not an “enemy” of religion per se, Mill was clearly convinced that the purportedly “incomplete and one-sided” moral doctrine of Christianity should not be permitted to dominate citizens’ “moral sentiments” to the lasting detriment of human progress. While the separation of Church and State is often characterised as an indispensable counter-balance to this type of stifling religious dogmatism, it could still be argued that attempts to dis-empower the religious community from having a meaningful impact on politics, is in contravention of the more compelling (Millian) liberal principle of tolerance for diversity.

It is arguably inappropriate to suggest that people of faith must limit their sphere of activity to internal ecclesiastical matters, as the liberal–democratic State ideally formulates policy in response to the needs and objectives of its citizens. In expressing support for AVE, for example, the State and its policy making representatives must first collude on whether this practice constitutes a moral and/or publicly acceptable outcome. The decision made will invariably be influenced by one or more philosophical assumptions and so there is no satisfactory reason to exclude rational religious perspectives from competing with or being seen as an adjunct to, secular views. This may not be possible, however, if advocates of

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96 Sweetman, op.cit., p.202


98 Sweetman, loc. cit.
Church–State separation continue to question the motivation of politicised Christians rather than the credibility of their respective arguments. As such, Maddox has stipulated that policy makers who wish to incorporate faith based views into their “political personae” owe their constituents an “explanation” as to where this expression of religiosity “fits” in public life.\(^99\) Fortunately, this call for transparent deliberation need not detract from (Christian) politicians’ and the broader Church community’s capacity to challenge (AVE) legislative reform on the basis of (arguably) irresolvable (patient) welfare concerns.\(^100\) It should be inconsequential whether opposition to AVE reform is based upon rational religious assumptions about a human frailty inspired slippery slope risk or, for example, because of secular concerns about the need to venerate and protect innocent human life in a civilised society. While it is conceded that religiously motivated opponents, in particular, have undermined the reform agenda, right to die advocates clearly need to accept that the liberal–democratic political process must remain open to all responsible views in religion infused ‘secular’ cultures.\(^101\)

It was earlier alluded to in this discussion that the religious lobby need not be excluded from political debate, only that arguments over policy should be expressed in ‘universal’

\(^99\) It bears emphasis that Maddox is not advocating religious exclusion in political and public life only that “faith based politics” should not be treated as being “beyond discussion or critique”. See: Maddox, God Under Howard, p.314

\(^100\) V Bader, “Religious Pluralism – Secularism or Priority for Democracy?”, Political Theory, Vol.27, No.5, October 1999, p.601

\(^101\) While most mainline Catholic and Protestant Churches hold to an official line against euthanasia reform, the fact remains that not all Christians agree that AVE is impermissible as there is considerable support for this last resort practice amongst members of the Church laity. See further Dutney, op.cit., pp.129–131 & p.144
By directing citizens to appeal to common or shared themes it is maintained that there is a greater likelihood of reaching popular agreement on complex and emotive issues, as the legitimacy of State policy is reliant upon some form of ‘transparent’ rational justification that goes beyond potentially subjective religious claims. This is far from a benign view, however, as it is likely to dis-empower rather than underwrite religious influence in the political arena. More to the point—how are members of the Church to defend doctrinal ideals when secular reason and secular language sometimes fails to accommodate ‘rational’ religious convictions? How would Christian lobbyists justify reverence for the sanctity of human life on the issue of abortion, for example, when secular society characterises a foetus as a non-human entity? Counter-arguments about God having an interest in the foetus while still in the womb or that the unborn are a unique creation made in His image cannot be adequately communicated using secular language.

Similarly, if a secular utilitarian rationale was used to justify non-voluntary and involuntary active euthanasia on personhood or greater good grounds, how might Christians express their opposition? Would alternate claims about a ‘secular sacred’ be sufficiently compelling to challenge the perceived greater good achieved by imposed terminations? While it could be argued that a secular sacred sanctity of life rendering is itself inherently flawed because it is open to perpetual re-evaluation, less sceptical thinkers


104 Genesis 1:27 & Jeremiah 1:5

maintain that it is a preferable option to unduly rigid religious assumptions. While there is no question that citizens have a right to advocate this controversial secular viewpoint in a liberal–democratic society, the idea that religious lobbyists should be imposed upon to justify their competing beliefs in strictly secular terms is plainly discriminatory and detrimental to the (liberal) principle of social diversity.

While it is possible to oppose active euthanasia reform on secular ‘do no harm’ or ‘slippery slope’ grounds, the idea that secular values should become the sole point of reference for public policy fails to appreciate the potentially beneficial role that religious beliefs can play in political affairs.106 Consider, for example, civil rights campaigner Martin Luther King Jr.’s depiction of the Church as the “chief moral guardian of the community” and “conscience of the State” as a vindication of the defining role that religious citizens can play in speaking out against immorality.107 This ‘moral auditor’ function may be particularly important in a post-euthanasia reform environment, as concerned Christian constituents could conceivably fulfil their spiritual and temporal obligations by ensuring that vulnerable patients are dealt with in a compassionate and just fashion.108 If the Church were to be denied the opportunity to have a tangible role in influencing related public policy and the end of life options that spring from it, then the Christian political lobby may well be proven right when they argue that secular society’s vulnerability to moral


impropriety (such as euthanasia abuse) would be accentuated.\textsuperscript{109} It bears emphasis, therefore, that sections of the Church community have been at the forefront of protests (against abortion on demand, for example) aimed at transcending assumptions about self determination as the highest good, by exposing the risks of tolerance without discretion.\textsuperscript{110}

On the other side of the coin, it is fitting that those elements from within the religious community who are disturbed by social diversity and individual moral agency have been criticised for seeking to regulate the most intimate aspects of other people’s lives.\textsuperscript{111} On the issue of choice in dying, for example, it should still be possible for religious devotees to petition for stringent legislation that adequately protects the vulnerable without seeking to overrule the ‘God ordained’ capacity of rational terminal patients to enter into a self prescribed beneficent (AVE) arrangement. In spite of the fact that some from within the Church have counter-claimed that the legalisation of AVE is akin to the vindication of assisted dying as a ‘moral act’ it must, nevertheless, be acknowledged that it is not the place of Christians to overrule the democratic process in relation to policy that protects a rational individual’s (strictly self regarding) end of life preference.\textsuperscript{112} Indeed, if God


\textsuperscript{112} Sweetman, op.cit., pp.136–137. See further Dutney, op.cit., pp.132–133. Dutney’s exploration of (liberal) Christian theological arguments in favour of choice in dying contends that submission to blind fate contravenes the overriding principles of (conscientious) self determination and (compassionate) beneficence.
Himself is not prepared to save people from eternal destruction against their will, then neither too should Christians feel that they have an obligation to intolerably distressed terminal patients that goes beyond ensuring that they are competent, informed, and willing participants in a last resort AVE termination. And so it is proposed that while Christian politicians and activists have every right to pursue their lawful spiritual convictions on the distinctly moral issue of end of life policy, they can still honour their religious conscience by enabling suitably informed constituents to decide for themselves on the merits of State sanctioned AVE.

Conclusion

At the outset of this discussion it was observed that the conservative Christian lobby’s opposition to AVE reform is broadly representative of orthodox religious thought. The tendency of some Christian groups to translate this pro-life conviction into political action was, however, characterised as an affront to others who favour the principle of Church–State separation. While it was conceded that the US constitutional Establishment Clause has sometimes been interpreted as prohibiting religious involvement in ‘secular’ policy affairs, a more compelling argument was made that the predominantly Christian Founding Fathers never intended to ensure freedom from religion but rather, freedom for religion. In light of the fact that the Fathers anticipated that religion would play a defining role in nurturing a moral community, it was only fitting that the Church has maintained a tradition of asserting itself in ‘secular’ policy affairs. The tendency of ‘born again’ President George W. Bush to exhibit sympathy for the (pro-life) moral agenda of conservative Christian constituents, nevertheless, prompted expressions of disapproval from commentators who

feared that the White House and the Republican Party’s relationship with the religious right was undermining objective policy making. These concerns were arguably vindicated following an extraordinary Republican led Congressional intervention aimed at saving the life of PVS patient Terri Schiavo. Although the Judiciary ultimately ruled against Washington’s pro-life power-brokers in favour of Schiavo’s pre-ordained wish to be released from a burdensome existence, critics had clearly been right to challenge contrary minded Christian activists’ and their Congressional sympathisers’ unduly invasive tactics, as an exhaustive legal process had already established that the patient’s rights had been meticulously accounted for.

The difficulty in ensuring a balance between religious expression and freedom of conscience was also depicted as an issue of concern in Australian politics. Indeed, it was observed that the authors of the Australian Constitution took their cue from the US Founding Fathers by leaving the way open for the Church to have a role in the framing of social policy. In accordance with this view it was reported that the conservative Howard Government’s own internal pro-life ‘Christian’ lobby—the Lyons Forum—had, more recently, underwritten Canberra’s decision to disallow the Northern Territory’s democratically instituted ROTTIA. While it was observed that members of the Labor opposition, in particular, accused Forum members of seeking to impose an unrepresentative Christian agenda upon contrary-minded Territorians, the Parliamentary record indicated that there was a distinct muting of religious rhetoric in support of this Andrews Bill initiative. This led to the credible claim from Maddox that Christian politicians had consciously played down their faith based convictions in favour of less divisive mainstream arguments.
While it was ultimately self-evident that Christian lobbyists and their parliamentary sympathisers were opposed to the Territory law, a lack of explicit religious language in favour of the ROTTIA’s disallowance failed to dissuade other MPs from warning that ‘secular’ political representatives should not cast a (conscience) vote on the basis of ‘private’ religious justifications. Although the ROTTIA’s disallowance provoked similar criticism from members of the public, it was argued that the separation principle should not have been viewed by advocates as a means of disarming or otherwise excluding (religiously minded) political opponents from pursuing what they believed was a conscientious policy objective. It was further asserted that a strict separation interpretation contravened the core liberal–democratic preference for freedom of conscience and social diversity. Although there was no question that policy deliberations needed to be transparent, the idea that Christian MPs should have to justify all policy objectives on the basis of distinctly limiting secular language was characterised as placing members of the Church at a particular disadvantage, as it is not always possible to enunciate arguably rational religious convictions in purely secular terms. In making the point that all parties should be entitled to have their say in a liberal–democratic society it was, nevertheless, conceded that the resistance of some Christian groups to beneficial AVE reform unduly disadvantaged intolerably distressed patients. It was suggested, therefore, that religious groups should not stand in the way of ‘God-given’ end of life choice but should focus instead upon a ‘moral auditor’ role that respects self regarding rights whilst still ensuring that the interests of vulnerable patients are suitably accounted for. The chapter to follow will further explore this issue of euthanasia reform by investigating the liberal–democratic citizen–State relationship and the limits of administrative oversight in end of life affairs.
7 THE STATE AND END OF LIFE POLICY

Introduction

In light of the previous chapter’s examination of religiously motivated interventions in the end of life debate, the discussion will now focus upon an analysis of the ‘secular’ liberal–democratic State’s role in the administration of euthanasia policy. While it will initially be acknowledged that the State is the chief guarantor of citizen security with the protection of vulnerable or impulsive citizens from arbitrary or unnecessary terminations as an implicit social contract obligation, it will be argued that there are clear limits to just how far this paternal ideal should extend. In order to clarify the extent to which State intervention in end of life affairs is warranted, a critical eye will be passed over Australian suicide prevention policies, United States (US) Attorney General John Ashcroft’s controlled substances intervention against Oregon’s Death with Dignity Act, and Washington’s attempt to preserve the life of persistent vegetative state (PVS) patient Terri Schiavo.

The Liberal–Democratic Citizen–State Relationship

Within the realm of Western political discourse the State has been characterised as a “human community which successfully lays claim to the monopoly of legitimate physical violence within a certain territory”.1 Liberal–democratic States have traditionally sought to regulate this authority via a social contract, which invites citizens to exchange the tenuous option of absolute (state of nature) autonomy in preference for civil liberty and property

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rights.\textsuperscript{2} Despite the fact that the State’s capacity to bring to bear irresistible force in support of these fundamental interests is itself reliant upon the collective cooperation of the people, it bears emphasis that this arrangement need not preclude social diversity.\textsuperscript{3} Indeed, democrats have sought to manage inevitable pluralistic ambitions to the extent that the popular will is adopted as the most appropriate guide to public policy.\textsuperscript{4} This constituent driven approach is informed by both pragmatic and ethical considerations, as policies which fail to attract an absolute majority of direct or preference based voter consent are deemed as potentially unsustainable or otherwise misguided.\textsuperscript{5} The liberal–democratic State is, thus, conceived as an instrument of the people with its constituent endorsed trustee representatives obligated to remain open and responsive to the legitimate policy proposals and criticisms of the electorate.\textsuperscript{6}

While it behoves politicians to exhibit sensitivity to the public mood, it is conceded that they must sometimes assert discriminating authority when confronted with ill-conceived or


\textsuperscript{4} C Cohen, \textit{Democracy}, University of Georgia Press, Athens, 1971, p.65


poorly devised policy proposals. More specifically, under conditions where the public lacks knowledge, discernment, or foresight, the responsibility of evaluating optimal policy is a duty that is arguably best undertaken by a competent and adequately informed representative. Critics of this *trustee principle* have, nevertheless, counter-argued that it is unreasonable to assume that even the most conscientious representative can adequately account for the interests of constituents who characteristically manifest a variety of needs and aspirations. The fact that representatives sometimes fail to justify their decisions to overlook constituent petitions in favour of an *independently* conceived greater ‘good’ has reinforced these accountability deficit concerns. Hanna F. Pitkin’s assertion that representative governance enables less scrupulous politicians to act out of “ignorance and self-seeking” is, therefore, a pertinent complaint. Related concerns about undue administrative paternalism and questionable policy decisions lead to the conclusion that citizens need to be wary of developing an *over-reliance* upon the intellectual and notoriously persuasive powers of political representatives. Indeed, those citizens who are prepared to submit to the alleged better judgment of politicians are vulnerable to all

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10 Pitkin, *The Concept of Representation*, pp.210–211


manner of autocratic and potentially detrimental rulings. For example, one could argue that Australian and US politicians have exerted undue authority in denying citizens the legitimate option of last resort active voluntary euthanasia (AVE).

**State Paternalism in End of Life Affairs**

Opposition to State sanctioned AVE is typically informed by (slippery slope) fears that legalisation would place vulnerable citizens at an unacceptable risk. If one assumes that this is likely to be the case, then legislative restraints are clearly warranted as the protection of citizens from what John Stuart Mill once described as “private violence” is the primary duty of government. Those in favour of AVE reform have pointed out, however, that a pre-occupation with slippery slope concerns can undermine (liberalism endorsed) individual sovereignty and the (democratic) principle of constituent driven policy. In the latter case, it bears reiteration that opinion polls have consistently indicated that the majority of Australian and US citizens support the option of last resort AVE. It is an anomaly, therefore, that pro-choice lobbyists repeated attempts to pass right to die

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legislation has typically only wrought disappointment.\textsuperscript{17} This arguably inequitable situation has arisen despite the fact that citizens are, according to Mill, entitled to exert “ultimate controlling power” over the State and to expect in return that legislators will impose “as little control…over them in any respect, as is consistent with attaining the legitimate ends of government”.\textsuperscript{18} Having, thus, taken reasonable steps to preserve citizen security it should be apparent to \textit{all} legislators that the State lacks any further basis upon which to justify a prohibition against the practice of strictly regulated AVE.\textsuperscript{19} Indeed, politicians must be continually reminded that paternal measures are only called for under circumstances where an end of life practice would impose a tangible unwarranted harm.\textsuperscript{20} If there is no such evidence, then it would appear reasonable to expect that State intervention in end of life decision making should not go beyond the point of ensuring rational and informed consent.\textsuperscript{21} This minimally invasive approach only becomes less compelling \textit{if} one assumes that \textit{all patients} who seek a compassionately orchestrated ‘good death’ are inherently misguided or otherwise incompetent.\textsuperscript{22} Euthanasia advocates insist, however, that this

\begin{itemize}
\item \textsuperscript{17} Nitschke & Stewart, op.cit., p.87
\item \textsuperscript{18} Mill, “Considerations on Representative Government”, p.293
\item \textsuperscript{19} Please refer to Chapter Four for a discussion on self and other regarding harms.
\item \textsuperscript{22} J Harris, \textit{The Value of Life}, Routledge and Kegan Paul, London, 1985, p.80
\end{itemize}
contentious claim should not be relied upon in order to disenfranchise the moral autonomy of other carefully assessed rational patients.23

The State and Suicide Advocacy

It is often argued that patients who are denied the option of an AVE procedure remain free to pursue a suicide alternative and yet, the Australian Government maintains that the prevention of this “tragic” practice is a policy “priority”.

Indeed, one of the more significant decisions undertaken by the (Howard) Federal Government in the area of suicide prevention has involved a prohibition on the importation and exportation of suicide devices.25 Prominent euthanasia reform advocate Dr. Philip Nitschke was amongst the first to challenge this law, after having been thwarted in an attempt to take the self-styled Co-Gen suicide machine to the US. Whilst Nitschke has long maintained that “people have a right to dispose of [their] life whenever they want”, Sydney Custom’s (2003) interception would clearly have been welcomed by US authorities who are committed to reducing the nation’s alarmingly high (30 000) annual suicide death rate.26 Certainly there is a similar


need to curb the rate of suicide in Australia, as over 2 000 people a year (including a disproportionate percentage of youths) choose to die by their own hand. Canberra’s resolve to reduce these potentially needless deaths has more recently led to the (2005) Suicide Material Offences Act (SMOA) which bans carriage service (i.e. fax, email, or internet) transmissions on the practicalities of terminating life. Under the Act those who counsel or incite suicide can be penalised with a substantial fine of $110 000, which is in addition to already lengthy custodial sentences established under State and Territory law.

Commenting on this newly enshrined material offences legislation, Prime Minister John Howard and Health Minister Tony Abbott agreed that legislators had a duty of care to ensure that the law reflected the community’s opposition to the incitement of suicide. Pro-life lobbyists, such as the Australian Federation of Right to Life Association’s Kath Woolf, were quick to endorse this perspective, expressing the view that the SMOA helped better protect vulnerable citizens from so called “suicide spruikers who are happy to sell their one-off solution to anyone”. Woolf further affirmed that the policing of suicide


27 Pyne, Parliamentary Secretary to the Minister of Health and Ageing.


30 L Allison, “Death by Hansard”, Advertiser, 31 August 2006, pp.1–2
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Notwithstanding the lesser issue of monetary investment, it was equally well understood that any reluctance on the part of the State to tackle this form of \textit{indiscriminate} communication would risk conveying the message that killing oneself was a convenient solution to \textit{all} manner of suffering.\footnote{WJ Smith, \textit{WWW.Suicide – Suicide Advocacy goes Online}, Discovery Institute, 12 June 2003, viewed 23 August 2006, <http://www.discovery.org/scripts/viewDB/index.php?command=view&id=1488&printerFriendly=true>.} Any such assumption is particularly problematic, given that suicides often arise out of a treatable chemical imbalance in the brain or as a response to adverse—yet not necessarily insurmountable—life circumstances.\footnote{KR Jamison, \textit{Night Falls Fast – Understanding Suicide}, Picador, London, 1999, p.184. See further A Alvarez, \textit{The Savage God – A Study of Suicide}, Bloomsbury, London, 2002, p.116
}

Whilst suicide prevention is a well established policy objective, Attorney General Philip Ruddock was quick to hose down suggestions that the \textit{SMOA} is in any way designed “to stifle legitimate debate on euthanasia”.\footnote{Commonwealth of Australia, \textit{Hansard}, No.6, 10 March 2005, p.5
}

Persons involved in “genuine” reform discussion need not be alarmed by this legislative measure, agreed Senator Chris Ellison, because there would be no intention to “counsel’ or incite suicide”.\footnote{C Ellison, Minister for Justice and Customs, \textit{Suicide Prevention in Australia Strengthened by New Laws}, Attorney Generals Department, Australian Government, Canberra, 24 June 2005, viewed 19 April 2006, <http://www.ag.gov.au/agd/WWW/justiceministerHome.nsf/D2801B61EABE80A2CA>.} The Federal Government’s resolve to minimise the exposure of citizens to questionable end of life material has, nevertheless, dealt a significant blow to pro-choice activities. The internet, in particular,
had previously been utilised by euthanasia activists as a means of providing citizens with informative material in the face of unduly restrictive AVE regulations.\textsuperscript{36} Despite the fact that lobby groups such as Exit International do not counsel or incite suicide, its chief spokesperson Philip Nitschke expressed opposition to the SMOA on grounds that it represented an unduly “heavy-handed blunt censorship approach” to end of life affairs.\textsuperscript{37} Not to be outdone, Nitschke and co-author Fiona Stewart have since published the \textit{Peaceful Pill} handbook which offers readers advice on suicide techniques ranging from simple plastic bag methods to more complex carbon monoxide and cyanide options.\textsuperscript{38} As a consequence of the sensitivity of the material covered, the Office of Film and Literature Classification Board designated the \textit{Peaceful Pill} as a restricted (i.e. available only to those 18 years and over) Category One publication. Although some 3 000 copies had already been sold overseas, an attempt by Nitschke to import the handbook from a US printer was foiled by Brisbane Customs officers on grounds that the content was viewed as inciting suicide.\textsuperscript{39} Further concerns were also raised about the text’s description of how people have successfully acquired the banned (lethal) substance of Nembutal from Mexico, and the manner in which they evaded US and Australian Customs’s intervention upon their return.\textsuperscript{40}

\begin{thebibliography}{99}
\item Nitschke, op.cit.
\item A Stafford, “Ruddock Appeals Suicide Book Release”, \textit{Age}, 13 January 2007, p.9
\item T Ong, “Mercy Killing Drug Instructions in Book”, \textit{Australian}, 1 March 2007, p.3
\end{thebibliography}
Although the *Peaceful Pill* remained approved for publication within Australia, Attorney General Philip Ruddock appealed the Classification Review Board’s decision on grounds of an “apparent anomaly” in the law.\(^\text{41}\) Indeed, Ruddock maintained that there was need for a more “consistent approach” to publications that incited people to “carry out a criminal act”:\(^\text{42}\) The Board evidently saw merit in this claim, as the *Peaceful Pill* was ultimately removed from sale (in February 2007) on grounds that it “instructs in the crime of the manufacture of barbiturates”.\(^\text{43}\) Having succeeded in denying people “the best information” about suicide, Philip Nitschke maintained that the Australian Government had again shown itself willing to perpetuate an unduly paternalistic agenda.\(^\text{44}\) Nitschke went on to conclude that “free speech is dead in Australia”, as the Government’s actions allegedly highlighted its intent to “push ideas, words and speech underground”.\(^\text{45}\) A spokesperson for the Attorney General responded to Nitschke’s additional allegation that the Review Board had effectively succumbed to pressure from the Federal Government, right to life groups and so-called “Christian reactionaries”, with the reassurance that the Board was “completely independent”.\(^\text{46}\) Irrespective of any lingering suspicions about a culture of coercion, Nitschke and his supporters arguably failed to recognise that the issue was not about how

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\(^{41}\) “Suicide Manual Rethink”, *Australian*, 13 January 2007, p.9


\(^{43}\) L Kennedy & B Cubby, “Police to Question Nitschke over Death”, *Sydney Morning Herald*, 1 March 2007, p.3

\(^{44}\) P Jackson, “Ruddock Bid to Stop ‘Death’ Book”, *Australian*, 14 January 2007, p.2

\(^{45}\) Rushworth, op.cit., p.6

\(^{46}\) ibid., see further Wheatley, op.cit., p.13
the Board’s censorship decision was arrived at, but rather the basis upon which that decision was made.

Even if one concedes that legislation such as the *SMOA* has made end of life undertakings that much more difficult, it could still be argued that this shortcoming does not justify abandoning impulsive individuals to the mercy of freely available suicide tutelage.47 Others including Kep Enderby of the Voluntary Euthanasia Society of New South Wales took a different view, however, having maintained that the Federal Government’s (*SMOA*) decision to censor internet access was an over-reaction to a non-existent domestic problem.48 The Government responded to this criticism with Senator Ellison drawing upon data from the United Kingdom which indicates that a number of people who have accessed suicide websites have later ended their lives.49 A similar circumstance has been reported in the US with 19 year old college student Suzy Gonzales utilising information provided from one such website in order to formulate and ingest a life-ending potassium-cyanide solution.50 These international precedents have arguably served to ratify Canberra’s misgivings about internet based suicide sites, in particular, as non-discerning realms that provide inadequate protection for impressionable or mentally unbalanced individuals. Under the circumstances, it would be highly irresponsible of any lobbyist to seek to redress


50 Smith, *WWW.Suicide*. 
the present lack of a legalised AVE or PAS alternative (for intolerably distressed terminally ill citizens) by enabling the secondary problem of impulsive suicide amongst the broader population. Given that the State’s duty to protect the lives of *irrational* people is not in question, it is reasonable to conclude that the Australian Federal Government has behaved in a responsible fashion by implementing discriminating measures aimed at preserving the interests of individuals who—unlike intolerably distressed terminal AVE candidates—might otherwise have forfeited a life that they could later come to value.

**The State and Assisted Suicide**

In contrast with the legitimate anti-suicide measures adopted in Australia, US Attorney General John Ashcroft’s attempt to undermine Oregon’s constituent endorsed *Death with Dignity Act (DWDA)* proved to be a distinctly questionable undertaking. Described by *CQ Weekly* as the President’s “most controversial Cabinet nomination”, Ashcroft had been confirmed in the position of Attorney General by a relatively narrow 58 to 42 margin.\(^{51}\) Judiciary Committee Chairman Orron G. Hatch was amongst the first to endorse this appointment, claiming that Ashcroft’s “distinguished…record of enforcing and upholding the law” inspired a sense of “security”.\(^{52}\) Opponents of the appointment expressed entirely different sentiment, however, citing reservations about Ashcroft’s impartiality in the face of laws that failed to meet with his ultra-conservative moral ideals. In particular, Ted Kennedy (D) referred to Ashcroft’s longstanding record of “intense opposition” to “issues involving civil rights, women’s rights, gun control and [liberal Judicial and political]

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\(^{52}\) ibid., p.287
nominations”.55 Whilst the Attorney General was quick to reassure his critics that present laws would continue to be appropriately enforced, Ashcroft’s November 2001 challenge against Oregon’s DWDA (on grounds that drugs supplied under Federal auspices could only be dispensed for the well-being of patients and not for physician-assisted suicide) appeared to validate the concerns of Kennedy and others.\textsuperscript{54} Citing the Controlled Substances Act (CSA), Ashcroft explained that the dispensing of drugs for routine pain management purposes was vastly different to that currently practiced under Oregon law.\textsuperscript{55} The Ashcroft directive further advised that PAS served no “legitimate medical purpose”, and that any physician who participated in this practice was acting in a manner which was “inconsistent with the public interest and [would] therefore [be] subject to possible [registration] suspension or revocation”.\textsuperscript{56}

The State of Oregon immediately lodged a protest against the Ashcroft ruling in the District Court, accusing the Attorney General of having failed to fulfil his obligation to first consult with local authorities in order to determine if the directive was consistent with the “public interest”.\textsuperscript{57} Whilst the plaintiffs maintained that the viability of the DWDA

\textsuperscript{55} ibid.
would be placed in jeopardy if the directive were ratified, they further alleged that this intervention not only discounted the Supreme Court’s (1997) *Washington v. Glucksberg* ruling that assisted suicide was an *intra-State* matter, but that it also breached Constitutional convention.\(^{58}\) More specifically, the Tenth Amendment was invoked as affirming that “The powers not designated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people”.\(^{59}\) In spite of this seemingly credible defence, the Federal Government’s case had been buoyed by Chief Justice Rehnquist’s rebuttal of claims that a statutory “prohibition against ‘caus[ing]’ or ‘aid[ing]’ a suicide offends the Fourteenth Amendment” of the Constitution.\(^{60}\) Suffice to say that this particular Amendment stipulates, in part, that no State shall “deprive any person of life, liberty, or property, without due process of law”.\(^{61}\) Rehnquist concluded that the State of Washington’s ban on assisted suicide was not only demonstrative of a commitment to preserve the sanctity of (innocent) human life, but also a “consistent and enduring theme” in US “philosophical, legal, and cultural heritage”.\(^{62}\)

An appeal to the Fourteenth Amendment’s liberty doctrine in order to demonstrate an implied ‘right to die’ was, subsequently, rejected as conflicting with the States’

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\(^{59}\) Grant & Ashbee, op.cit., p.43.


\(^{61}\) Grant & Ashbee, op.cit., p.46

“unqualified interest in the preservation of human life”. The counter-proposal that a patient’s medical condition and personal wishes could somehow absolve or negate this undertaking had earlier been discounted by a Court of Appeals ruling that “all persons’ lives, from beginning to end, regardless of physical or mental condition, are under the full protection of the law”. At that particular time, the Court of Appeals clarified that the State’s interest goes “beyond protecting the vulnerable from coercion” to that of defending the “disabled” and the “terminally ill” from “negative and inaccurate stereotypes, and societal indifference”. A complicit Chief Justice Rehnquist was prepared to concede, however, that the current “debate about the morality, legality, and practicality of physician-assisted suicide” should be permitted to continue in a “democratic society”. This concession highlighted the Court’s recognition that the potential for further (PAS) legislative reforms could never be entirely ruled out, and that, despite the rancour of contrary-minded Federal ideologues.

Whilst Rehnquist’s colleague Justice O’Connor expressed an enduring faith in the capacity of liberal–democratic communities to find “the proper balance between the interests of the terminally ill…and the State’s interests”, the need to protect the incompetent and dying from involuntary terminations purportedly justified an ongoing prohibition against PAS. In a concurring statement, Justice Stevens observed that “The value to others of a person’s life is far too precious to allow the individual to claim a constitutional entitlement to complete autonomy in making a decision to end that life” [emphasis added]. Whilst Stevens agreed that the “Due Process Clause does not include a categorical ‘right’ to

63 ibid.

64 ibid.
commit suicide”, Oregon authorities took consolation in the Justice’s admission that occasions can arise when the consultative practice of “hastening death is legitimate” and, indeed, “entitled to constitutional protection”. Stevens affirmed that patients who are near death have “a constitutionally protected interest [in physician-assisted-suicide] that may outweigh the State’s interest in preserving life at all costs” [emphasis added]. It was further surmised that an intolerably afflicted terminal patient’s (rational) concern in living or dying need not, therefore, be construed as an overriding public interest but rather, as “an aspect of individual freedom”.

Justice Stevens’s compelling logic failed to dissuade John Ashcroft—and later Alberto Gonzales, as the Attorney General’s Department vigorously pursued a Judicial ruling that would conceivably diminish the likelihood of an optimal end of life experience. Critics such as Jonathan Adler were moved to question this invasive Federal tactic, given that States were otherwise left to freely impose capital punishment and to regulate “laws governing end of life medical treatment and…advanced directives”. Adler further contended that in adopting the role of “moral babysitter”, the Federal authorities had discounted the fact that the CSA was designed to police the “illegal sale and distribution of drugs” and not to “micromanage the practice of medicine”. The Federal Government’s decision to pursue a conflicting agenda was not particularly unique however, as political observers had previously noted Washington’s historic tendency to favour their own

65 ibid.

66 ibid.

judgments over those arrived at by the States.\textsuperscript{68} The Administration’s focus upon addressing traditional conservative grievances (such as abortion rights) had, in the minds of other critics, also been a mitigating factor in this ideologically driven attempt to undermine Oregon’s popularly endorsed \textit{DWDA} legislation.\textsuperscript{69}

Oregon’s Congressional Delegation responded to the Attorney General’s challenge, alleging that Ashcroft had improperly invoked Federal law as a means to “proscribe as illegitimate those medical practices that fail[ed] to conform to his moral convictions”.\textsuperscript{70} Although Ashcroft was careful to avoid the implication that this intervention was motivated by anything other than a legitimate legal grievance, the fact remained that the Attorney General’s initiative was being pursued at the cost of alienating liberal–democratic principles including freedom of choice and the sovereign rights of (State based) citizens. The refusal of Oregon authorities to accede to Federal pressure was formerly acknowledged after State officials were granted a temporary restraining order from the District Court in November 2001. A subsequent April 2002 hearing was resolved against the Ashcroft directive with Judge Robert Jones ruling that present \textit{DWDA} drug practices

\begin{footnotesize}
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\item \textsuperscript{69} C Tiefer, \textit{Veering Right}, University of California Press, Berkeley, 2004, pp.43–58 & p.320
\end{itemize}
\end{footnotesize}
could be legitimately maintained. In response, Federal petitioners immediately sought to have this decision overturned by the Ninth Circuit US Court of Appeals.\textsuperscript{71}

The Ninth Circuit Federal petition stressed that “the Congress intended the CSA to set uniform nationwide minimum standards for controlled substances”, and that this necessarily incorporated the right to define the boundaries of “legitimate medical purpose” [emphasis added].\textsuperscript{72} It was further reiterated that the Ashcroft directive’s opposition to PAS as an illegitimate clinical practice enjoyed “overwhelming support in tradition, history, law, and medical expertise”.\textsuperscript{73} Of particular note, however, the Federal Brief revealed the Attorney General’s underlying conviction that “the taking of drugs to commit suicide is a form of ‘drug abuse’” which purportedly contravened the CSA’s commitment to “health and safety”.\textsuperscript{74} Ashcroft’s determination to advance this contentious viewpoint was further evidenced by the documentation’s intimidating maxim that “Federal law does not yield even when it frustrates the purposes of State law”, and that “State’s are not free to displace the Federal-law duty to comply with the CSA”.\textsuperscript{75} Whilst it was reluctantly conceded that Oregon retained the right to express disagreement with CSA rulings, the Federal petition concluded that the “Attorney General is solely responsible for administering and


\textsuperscript{73} ibid., p.12

\textsuperscript{74} ibid., p.20 & p.45

\textsuperscript{75} ibid., p.14 & p.44
interpreting” the Act’s provisions [emphasis added]. Sympathetic commentators were swift to rally in support of this allegedly exclusive and “maximally expansive” interpretative right, warning that confusion and disorder would ensue if each of the Union’s fifty States were empowered to formulate their own independent drug policies.\(^77\)

In spite of predictions about an administrative quagmire, the Ninth Circuit Court resolved against Ashcroft’s interpretative assumption pointing to former Attorney General Janet Reno’s statement that the CSA was not “intended to displace the States as the primary regulators of the medical profession or to override a State’s determination as to what constitutes legitimate medical practice”.\(^78\) The Reno memorandum had further advised that the CSA “does not authorise [the Drug Enforcement Agency (DEA)] to prosecute, or to revoke DEA registration of, a physician who has assisted in a suicide in compliance with Oregon law”.\(^79\) Presiding Judge Richard C. Tallman duly reaffirmed comments made in the Washington v. Glucksberg ruling that “State governments bear the primary responsibility for evaluating physician-assisted suicide” under US federalism.\(^80\) Tallman concluded that it was plainly improper for the Attorney General to have attempted to “define the scope of legitimate medical practice” or to “regulate the [doctor–patient] relationship” in order “to

\(^{76}\) ibid., p.47


\(^{79}\) Reno, op.cit.

\(^{80}\) United States Court of Appeals for the Ninth Circuit, op.cit., p.6614
advance Federal policy”. Ashcroft also came under fire for having failed to heed that the CSA’s authority had been limited by Congress to specifically recognised acts of “drug abuse and addiction”. As Janet Reno observed in 1998, “The particular drug abuse that Congress intended to prevent was that deriving from the drug’s ‘stimulant, depressant, or hallucinogenic effect on the central nervous system’”. The State of Oregon’s Ninth Circuit Brief had made a point of responding to Federal concerns on this issue, by highlighting the fact that the substances utilised under DWDA provisos were legitimate Schedule II (generally prescriptive only) drugs, rather than Schedule I substances which are classified as having no officially sanctioned (medical) purpose. The Oregon Brief asserted further that there was no suggestion—nor could there be—on the part of Federal petitioners that the DWDA had enabled Schedule II drugs to be “diverted into illicit markets”, or, that the Act had “created a realistic possibility of diversion”.

The failure of the Attorney General to establish a credible complaint against DWDA practices emboldened Oregon respondents to describe the Federal directive as an “affront to State sovereignty”, in that it contradicted the Court’s recognition that local authorities have traditionally dictated the bounds of legitimate medical practice. It was further

81 ibid., p.6614 & p.6617
82 ibid., p.6620
83 Reno, op.cit.
85 ibid., p.14
86 ibid., p.21 & p.41
maintained that this unelected bureaucrat’s attempt to countermand the democratically established wishes of the citizens of Oregon, directly challenged the US federal system’s traditional recognition that contrasting national views have no influence over whether States retain the right to reach an independent decision on an internally governed matter such as PAS. Judge Tallman concurred that the Attorney General’s “unilateral attempt to regulate general medical practices historically entrusted to State lawmakers” had, indeed, improperly interfered with “the democratic debate about physician-assisted suicide and far exceed[ed] the scope of his authority under Federal law”. The US Supreme Court later responded to Federal petitions to revoke the Ninth Circuit Court decision (in January 2006) with a 6 to 3 resolution against the incumbent Attorney General Alberto Gonzales. In outlining the verdict Justice Anthony Kennedy echoed the concerns of the respondents, advising that Ashcroft’s precursory “interpretive rule” would have “radically’ shifted the Federal–State relationship, as “the authority claimed by the Attorney General [was] both beyond his expertise and incongruous with...statutory purposes and design” [emphasis added].


88 United States Court of Appeals for the Ninth Circuit, op.cit., pp.6625–6626

89 Department of Human Services, op.cit., p.7

Commenting on the Supreme Court decision, legal analyst Marcia Coyle observed that the Judiciary had been particularly sensitive to the fact that “the power to criminalise” physician conduct would have been “unrestrained” if the Federal Government’s case had prevailed.91 The idea of DEA employees being empowered with the authority to determine the legitimacy of complex pain management prescribing was also more widely interpreted by critics as posing a threat to the interests of patients.92 The fact that non-medically qualified DEA officers could have been consulted by literally “anyone” in order to adjudicate over a presiding practitioner’s “intent” would, said palliative care Specialist Russell Portenoy, have undermined the ability of medical staff to deal with severe pain amidst a culture where “under-treatment” was already commonplace.93 Robert Steinbrook of the New England Journal of Medicine surmised that some physicians would have remained sceptical about the ability of drug enforcement agents to accurately discern between “good practice and potentially illegal prescribing” [emphasis added].94 Certainly the threat of agency prosecution and a lengthy (20 year) Federal prison term could have resulted in these understandably cautious practitioners abandoning aggressive pain management strategies altogether.95 In response, Attorney General Ashcroft sought to downplay these damaging allegations by reassuring Oregon physicians that the Federal

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directive would not result in increased DEA “monitoring or investigation” of controlled substance (pain-relief) prescriptions.\(^{96}\)

Additional assurances that local physicians would be permitted to utilise alternate medications in aiding patients to hasten their death, appeared only to confirm fears about the Federal authority’s lack of regard for yet another (Court of Appeal) finding that **controlled substances** remained the most effective and reliable method of compassionately ending life.\(^{97}\) This “cruel rejoinder”, as the American Civil Liberties Union aptly described it, seemed to exemplify the Attorney General’s alleged indifference to the notion of despairing patients being compelled to endure an intolerable existence, or to otherwise resort to self-prescribed and potentially problematic life ending alternatives.\(^{98}\) Whilst Oregon’s terminal patient community was ultimately spared this injustice, critics of the Supreme Court ruling responded that the exoneration of PAS left the way open for all manner of slippery slope potentialities.\(^{99}\) The fact that Oregon authorities were able to demonstrate that the risk of assisted suicide abuses could be effectively managed not only discredited these critics, but also served to vindicate patients who were opposed to

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\(^{96}\) Ashcroft, op.cit., p.267


autocratic bureaucrats intervening in their private end of life affairs. In spite of that fact, the Bush Administration’s ideological zealotry remained undiminished as it would later set out to hinder a Florida patient’s (alleged) express wish to be released from a futile vegetative existence.

The State and Terri Schiavo

The ill-fated attempt of Florida State and Washington bureaucrats to preserve the life of 41 year old PVS patient Terri Schiavo became one of the most divisive political issues of 2004–2005. Whilst Schiavo had exhibited periods of apparent ‘wakefulness’ and automatic responses to some stimuli following heart failure in 1990, prevailing medical opinion confirmed that irreversible brain damage had robbed her of the capacity for wilful animation, emotion, or cognitive thought. In light of Schiavo’s permanently incapacitated state and absence of a documented Advance Directive, a Florida Court had appointed the patient’s husband, Michael Schiavo, as legal guardian. After four years of intense rehabilitation, Schiavo’s lack of meaningful recovery prompted her guardian to set in motion the necessary legal measures to honour the patient’s preordained wish not to be kept alive in a hopeless vegetative state. Notwithstanding assurances from Michael Schiavo and other family members who claimed to have been privy to Schiavo’s (pre-


PVS) verbal proclamation on this very issue, the patient’s parents insisted that their daughter’s life be sustained on grounds that she was ‘responsive’ and that her condition could be improved with additional treatment including (unproven) hyperbaric oxygen or vasodilator therapies. In response to the fact that no PVS patient has ever recovered after 15 years, Schiavo’s more pragmatic guardian chose to defy the wishes of Bob and Mary Schindler in acquiring permission from Circuit Court Judge George Greer (and later the Second District Court of Appeal) to have Schiavo’s feeding tube disconnected. Upon appeal from the Schindlers, the tube was reinserted two days later (on 26 April 2001) after a directive from Florida Circuit Court Judge Frank Quesada. This vacillating legal contest would again come to a head when approval was granted for Schiavo’s life-sustaining feeding apparatus to once more be removed, in October 2003.

As it became evident that the Schindler’s legal options were fast running out, the Florida legislature succumbed to family and pro-life lobby group pressure by stepping in to pass an extraordinary Bill providing an indefinite:

one-time stay in certain cases where the action of withholding or withdrawing nutrition or hydration from a patient in a permanent vegetative state has already occurred and there is no written advance directive and a family member has challenged the withholding or withdrawing of nutrition and hydration.

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105 Hook & Mueller, op.cit., p.1452

In response, medical staff were ordered to provide immediate sustenance to Schiavo via “gastronomy tube, or by any other method appropriate”.\(^{107}\) Much to the chagrin of Governor Jeb Bush and those who had allied themselves in this contentious separation of powers challenge, the Florida Supreme Court ruled (on 23 September 2004) that House Bill 35-E or *Terri’s Law* was unconstitutional. Indeed, it was concluded that the Florida Legislature’s improper—Court of appeal like—directive had not only violated the Judiciary’s right to adjudicate in individual cases, but had also undermined the guardian’s right to refuse extraordinary treatment.\(^{108}\) The validity of this decision was later affirmed by the US Supreme Court on 24 January 2005, after it refused to hear the appeal of State attorneys.\(^{109}\)

With some thirty prior Schindler–Schiavo Court rulings behind them, Michael Schiavo’s petition to release his now former wife from her burdensome existence was finally granted on 18 March 2005, by Florida’s US District Judge James Whittmore.\(^{110}\) Bob Schindler immediately sought to forestall this process by entreatyng the Congress to ensure that his daughter received a so called “fair trial”, by passing a Bill that would enable the case to be reviewed in the Federal Court. At the same time Schiavo’s mother Mary Schindler

\(^{107}\) ibid.


appealed directly to members of the community by imploring them to “call their Congressman” in support of this potentially life saving measure.\footnote{Barrett, \textit{House Debating Schiavo Bill}, CNN, 20 March 2005, viewed 21 March 2005, \texttt{<http://cnn.law>}.} A largely sympathetic Congress responded on 21 March by passing emergency legislation under the guise of the \textit{Incapacitated Person’s Legal Protection Act}—203 votes (comprising 156 Republicans and 47 Democrats) to 58 votes (comprising 5 Republicans and 53 Democrats)—allowing artificial fluid and nutrition withholding or cessation orders to be transferred for review to the Federal Court.\footnote{Congressional Record Online, \textit{For the Relief of the Parents of Theresa Marie Schiavo}, 20 March 2005, viewed 6 April 2006, p.H1728. \texttt{<http://www.gpoaccess.gov/index.html>}. See further Hook & Mueller, \textit{op.cit.}, p.1453.} Supporters of this controversial Bill maintained that Federal intervention was necessary to ensure that Schiavo’s Constitutional and statutory rights had not been violated by the prior Court’s (passive euthanasia) directive.\footnote{Congressional Record Online, \textit{op.cit.}, p.H1707}

The Schiavo appeal process was personally endorsed by President George W. Bush, having consistently maintained that “in cases like this one, where there are serious questions and substantial doubts, our society, our laws and our Courts should have a presumption in favour of life”.\footnote{Dalrymple, \textit{White House – Schiavo Bill not a Precedent}, ABC, USA, 21 March 2005, viewed 23 March 2005, \texttt{<http://abcnews.go.com/Politics/print?id=601101>}.} It was extremely important, the President said, to “build a culture” where “all Americans” are “valued and protected”, and most “especially those who live at the mercy of others”.\footnote{CNN, \textit{Bush – Millions Saddened by Schiavo’s Death}, CNN, 31 March 2005, viewed 30 April 2005, \texttt{<http://cnn.com/2005/US/03/31/schiavo.washington.ap/index.html>}.} This desire to “protect” the defenceless Schiavo from certain death also met with the approval of other senior politicians including the House Majority Leader Tom

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DeLay (R) who described this last-ditched intervention as a morally obligatory undertaking.\textsuperscript{116} James Sensenbrenner (R) employed more evocative language, having criticised the Florida Courts for imposing a so called “merciless directive” designed to “deprive Terri Schiavo of her right to life”.\textsuperscript{117} In spite of the fact that the quality of life of the patient in question appeared to be minimal, Sensenbrenner agreed with his Republican colleagues that the nation’s “compassionate traditions and highest values” demanded “action” in Schiavo’s defence.\textsuperscript{118}

In marked contrast with the emotive pleas of the interventionist lobby, Robert Wexler (D) reminded the chamber that some 19 State Judges had already concluded that the weight of evidence indicated that Terri Schiavo had \textit{no desire} to be kept alive in a persistent vegetative state.\textsuperscript{119} The suggestion that Congress should now attempt to implement a contrary measure that would effectively “overturn the separation of powers by disregarding the laws of Florida” and a legitimate judicial directive was, said Jim Davis (R), “a threat to democracy”.\textsuperscript{120} Notwithstanding the significance of this allegation, Debbie Wasserman-Schultz (D) maintained that it was equally inappropriate for the Congress to be implementing extreme measures in order to impose a partisan ideological stamp on what was an ideally “private” family matter.\textsuperscript{121} John Lewis (R) expressed in principle agreement

\begin{itemize}
  
  \item [117] Congressional Record Online, op.cit., p.H1701
  
  \item [118] ibid.
  
  \item [119] ibid., p.H1703
  
  \item [120] ibid., p.H1710
  
  \item [121] ibid., p.H1706
\end{itemize}
with this perspective, having argued that independent life and death decisions were being made “every day” by American families in accordance with “their own faith and led by their own hearts”. In light of that fact, Lewis questioned what had suddenly become of Congress’s much touted “respect for individual responsibility”, when the nation’s liberal–democratic representatives were willing to unilaterally disregard the foundational ideals of citizen autonomy and State’s rights.122

Aside from the matter of political consistency, John Conyers (D) and Barney Frank (D) compellingly argued that complex legal adjudications (such as those which had arisen in the Schiavo case) properly belonged in the hands of an ideally objective Judiciary and not a partisan Congress.123 The fact that Federal representatives had chosen to embrace a level of responsibility that was clearly beyond their expertise and jurisdiction merely fuelled speculation that this particular intervention masked a politically motivated rather than strictly compassionate agenda.124 Jim Moran (D) was convinced that this was the case, having asserted that the Federal initiative was “all about religion and politics”, with the patient in question viewed as a “political pawn” that would theoretically serve to “appease the interest groups” that kept incumbent politicians “in power”.125 As if to validate this suspicion, a leaked Republican Party memo had allegedly singled out the Schiavo affair as a so called “great political issue” that the influential “pro-life base will be excited” by.126

122 ibid., p.H1715
123 ibid., p.H1708 & p.H1720
124 ibid., p.H1708
125 ibid., p.H1712
New Republic editorial accused the President, in particular, of having thus “twisted” the “machinery of government” in order to satisfy the pro-life agenda of the American Right.\textsuperscript{127} Whilst veteran political analyst Mark Shields conceded that the initiative had all the hallmarks needed to strengthen President Bush’s crucial relationship with the powerful “religious and cultural conservative wing of his Party”, sceptics were left to ponder the apparent readiness of Republicans to contradict fundamental Party ideals.\textsuperscript{128} In USA Today, for example, Allan Lichtman pointed out that this predominantly Republican sponsored initiative was very much at odds with core conservative convictions about “the sanctity of the family, the sacred bond between husband and wife” and the ability of citizens “to make private decisions without the hand of Government intervening”.\textsuperscript{129} The fact that these principles could be overlooked, demonstrated the depth of (unrepresentative) private conviction and the lengths that some representatives were prepared to go in order to placate conservative (pro-life) interest groups.

In spite of a concerted effort to the contrary, the Congressional appeal was rejected (on 22 March) after Judge James Whittemore concluded that there was no cogent reason that prior State Court rulings should be invalidated.\textsuperscript{130} In fact, the Court rebuked the Federal legislature’s invasive action as being “demonstrably at odds” with “the governance of a


\textsuperscript{130} Hook & Mueller, op.cit., p.1453
free people”. The specific legalities of this decision were later clarified by Edward Lazarus, who pointed out that Congress had been found wanting for having improperly focused attention upon a single lawsuit “when legislation is supposed to be different from adjudication” because it “sweeps broadly, and is prospective”. The decision to ignore a multiplicity of State Judicial rulings had been a second point of contention under the principle of Constitutional Federalism. Finally, the Court found that the Constitutional right of a patient or (legally appointed) guardian to decline “extraordinary life-saving medical treatment” had been “impinged” and possibly even “violated” by the Congressional intrusion. This arbitrary attempt to impose Federal power was, subsequently, described by Constitutional expert Laurence Tribe as one that “no democracy” could “tolerate”. The nation’s Founding Fathers would likely have conceded as much, having been careful to implement measures designed to offset any such crisis of credibility by ensuring a separate Executive, Legislature, and Judiciary. Whilst it is customarily understood that each of these branches of government are intended to provide checks and balances upon the administrative authority of their counterparts, this ideal was clearly challenged by the US Executive and Legislature’s disregard for conventional legal and procedural mores.

131 CNN, Bush – Millions Saddened by Schiavo’s Death.


133 PBS, The Case of Terri Schiavo.

134 Grant & Ashbee, op.cit., p.20

135 Dorf, op.cit.
In the aftermath of Congressional action, an emergency (22 March) petition by the Schindler family to have their daughter’s feeding tube reinserted was denied, prompting Schiavo’s brother Bobby to protest to the waiting media that it was “absolutely barbaric” for any parent to have to see their daughter die in this bizarre fashion. Responding on behalf of the Administration, White House Press Secretary Scott McClellan made it plain that there had, indeed, been hopes for a very “different ruling” to the one provided. An evidently embittered Michael Schiavo remained unmoved by the comments of these now vanquished protagonists, having specifically accused the nation’s political representatives of violating his “personal and private life” in an unconscionable effort to deny his former wife’s explicit wish to be released from her burdensome existence. An ABC News opinion poll (of 20 March 2005) indicated a significant level of public sympathy for Michael Schiavo’s hard fought victory, with 63 per cent of respondents supporting the removal of Terri Schiavo’s feeding tube. A further 70 per cent of those surveyed indicated their explicit opposition to Federal intervention. These revealing statistics prompted political analyst Mark Shields to later comment that he’d “never seen such [an] overwhelming[ly] negative reaction on the part of the public” for a Congressional action.

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137 Franken & Sosa, op.cit.


140 ibid.

141 PBS, Shields and Brooks.
This dramatic public backlash had, indeed, left the nation’s political representatives in no
doubt that the majority of citizens deemed that contested end of life decision-making
should be objectively resolved in the Courts rather than by partisan Congressional
initiatives.142

With all life saving administrative avenues now fully exhausted, Terri Schiavo passed
away on 31 March 2005.143 In response, President George W. Bush and Governor Jeb Bush
agreed that people throughout the country and the world would be “deeply grieved by the
way Terri died”.144 Whilst expressions of remorse about the manner of Schiavo’s death may
not have placated the rancour of pro-life constituents, it bears emphasis that the patient’s
exposure to the symptoms of hunger and thirst would have been of a transient nature and
readily palliated.145 The very fact that Schiavo’s comfort care was meticulously attended to,
should have absolved State and Federal authorities of any further interest in the matter.146
Of course, this conclusion could have been drawn much earlier, as prevailing medical
opinion, the sworn testimony of a Court appointed guardian, and a series of exhaustive
judicial findings had confirmed Schiavo’s futile condition and/or right to die. If there had
been any doubts about the legitimacy of this decision they were all but dispelled after an
autopsy confirmed that the patient in question had indeed been “severely and irreversibly

142 RJ Blendon et al, “The American Public and the Terri Schiavo Case”, Archives of Internal Medicine,
Vol.165, 12 December 2005, p.2583

143 Quill, op.cit., p.1633

144 Phillips et al, op.cit.

145 ibid. See further Hook & Mueller, op.cit., pp.1456–1457

146 ABC News, Excerpts: Schiavo’s Death would be Peaceful, ABC, USA, 22 March 2005, viewed 23 March
brain damaged". The presiding Medical Examiner Dr. Jon Thogmartin went on to conclude that “no amount of therapy or treatment would have regenerated the [patient’s] massive loss of neurons”.¹⁴⁷ The fact that this finding validated earlier prognoses about the implausibility of meaningful recovery provided a timely reminder for the nation’s politicians to resist any future urge to favour an ideological agenda, over and above that of the apparent best interests of a scrupulously appraised patient such as Terri Schiavo.

**Conclusion**

Although the liberal–democratic State’s social contract obligation to provide a secure environment was never brought into question, this discussion has argued in favour of limited rather than unduly paternalistic governance in the management of futile and/or intolerably pained lives. Indeed, claims that statutory restraints against euthanasia are conducive with the State’s obligation to protect the lives of vulnerable citizens were challenged on grounds that a ‘good death’ is intended to be a freely orchestrated and beneficent undertaking. Active voluntary euthanasia was, therefore, shown to markedly contrast with the potentially unwarranted act of suicide, with policies aimed at preserving the lives of genuinely misguided or impulsive individuals acknowledged as legitimate expressions of administrative authority. Allegations that Australia’s *Suicide Material Offences Act* unduly curtailed individual rights were, thus, refuted by more compelling evidence that impressionable individuals would be placed at unnecessary risk if material aimed at counselling or inciting suicide was legally available.

It was argued that the Australian Government’s measured response to suicide ‘advocacy’ did not compare favourably with US Attorney General John Ashcroft’s autocratic directive aimed at eroding the viability of Oregon’s citizen endorsed *Death with Dignity Act*. This intervention went ahead in spite of evidence that Ashcroft’s attempt to deny the use of optimal Federal medications in PAS procedures was shown to be at odds with former Attorney General Janet Reno and the Judiciary’s collective interpretation of Federal law. The fact that there was no evidence to suggest that Oregon authorities had permitted these prescription only drugs to be diverted toward non-legal ends further exposed the Attorney General’s inability to justify Federal intervention in what was essentially an intra-State matter. Indeed, it was suggested that the interests of both patients and medical staff alike would have been placed in jeopardy had (non-medically qualified) Federal agents been permitted to adjudicate on the terms of ‘legitimate’ medical prescribing. The Court’s decision to overrule the Attorney General’s (arguably) ideologically motivated (controlled substances) directive as a violation of fundamental democratic and Constitutional principles was, thus, depicted as entirely appropriate. This incident also demonstrated why checks and balances are an indispensable part of good governance, as Ashcroft’s thwarted initiative exposed the lengths that some bureaucrats are prepared to go in order to satisfy private and/or unpopular partisan moral agendas.

US Federal and State authority’s ill-fated attempt to forestall the death of PVS patient Terri Schiavo was similarly criticised as an unduly heavy-handed intervention aimed at reversing a legitimate Judicial ruling in support of the patient’s (allegedly) explicit end of life preference. This challenge to Constitutional mores, the broader liberal–democratic commitment to individual choice and popular public sentiment, again exposed politicians’ willingness to misuse their administrative authority in order to appease personal convictions and/or powerful pro-life interest groups. Indeed, the Court’s rebuttal of the
Schiavo intervention on grounds that it undermined the patient’s civil rights was cited as a fitting response given that the integrity of the liberal–democratic system ultimately hinges upon a recognition of rational informed consent as the basis for credible (end of life) policy. It is intended that the remaining two chapters of the thesis will seek to reaffirm this and other core findings already referred to here and in previous chapters, with a political analysis of the Northern Territory’s Rights of the Terminally Ill Act (ROTTIA).
8 THE NORTHERN TERRITORY AND THE RIGHTS OF THE TERMINALLY ILL ACT

Introduction

In light of the previous discussion’s contention that the State should adopt a strictly limited (overseer) role in end of life affairs, this chapter will explore the Rights of the Terminally Ill Act (ROTTIA) in the knowledge that others have primarily focussed on the debate’s historic, religious or legal perspectives rather than upon a political theory analysis. Indeed, it is intended that this chapter will contribute to the field of existing ROTTIA literature by examining the liberal, democratic, utilitarian, and communitarian influences that defined the arguably under-analysed Northern Territory parliamentary debate. Despite evidence of a shared commitment on the part of the Territory Parliament to protect individual and communal interests, it will be demonstrated that there were a number of legitimate grievances that needed to be resolved if the ROTTIA was to be characterised as a responsible piece of legislation. By exposing these legislative shortcomings, attention will be drawn to the kinds of safeguards that are needed if AVE reform is to adequately protect

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the interests of all citizens. With these objectives in mind, the discussion will commence with an overview of the ROTTIA Bill’s first reading in the Northern Territory Parliament.

The First Reading of the ROTTIA

The ROTTIA was introduced as a Private Member’s Bill by the Northern Territory’s Chief Minister Marshall Perron on 22 February 1995. During the Bill’s maiden reading, Perron claimed that the pervasiveness of technologically prolonged dying, the demise of traditional religious authority, and an individual rights oriented culture had inspired increasingly vocal demands for greater end of life choice. Indeed, the overwhelming majority of Territorians had expressed support for the options of last resort active voluntary euthanasia (AVE) and physician-assisted suicide (PAS), leading Perron to inform the Parliament that politicians had a “duty to change the law” in order to reflect the popular will. In taking this opportunity to lodge a conscience vote in favour of the ROTTIA, the Chief Minister assured his fellow Territory representatives that they would not be getting ahead of public opinion but merely “catch[ing] up with it”. The importance of this initiative could not be overstated, as the reluctance of previous administrations to respond to the popular will had resulted in some Territorians having little other option than to die “slowly” and “agonisingly”. Perron went on to express understandable discontent with prevailing laws which dictated that no matter how “wretched” a patient’s life had

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2 Northern Territory Government, *Northern Territory Legislative Assembly – Rights of the Terminally Ill Bill (Serial 67)*, Legislative Assembly of the Northern Territory, 1995, p.1

3 ibid., p.3

4 ibid., p.8

become, they could not be mercifully terminated without their accomplice facing the prospect of criminal prosecution.\(^6\) More to the point, it seemed nonsensical that Territory law enabled patients to refuse life-preserving medical treatment on quality of life grounds, yet they were forbidden from seeking assistance in orchestrating an accelerated ‘good’ death.\(^7\) The proposed *ROTTIA* would not only rectify this legislative anomaly but equally importantly, Perron maintained that it would demonstrate to the nation that the Northern Territory had developed into a “mature” democracy that was committed to “acknowledging the rights of mature individuals”.\(^8\)

In outlining the scope of the Act, Perron explained that the *ROTTIA* provided legal immunity to physicians who were willing to comply with a suitably vetted terminal patient’s request for AVE or PAS.\(^9\) Mindful that this proposal would attract intense criticism, Perron set out to convince the Chamber’s philosophically opposed pro-life members that the Act offered a more accountable alternative to the current—albeit unspoken—practice of covert active euthanasia.\(^10\) Choosing to maintain the status-quo would, said Perron, mean that intolerably distressed Territorians would be left with no other option than to employ illegal, violent, or potentially unreliable methods of ending

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\(^6\) Northern Territory Government, *Northern Territory Legislative Assembly – Rights of the Terminally Ill Bill (Serial 67)*, p.1

\(^7\) ibid., p.3

\(^8\) ibid., p.6

\(^9\) ibid., p.2

their lives.\textsuperscript{11} While it was within the power of Territory politicians to ensure that these sorts of desperate actions were kept to a minimum, the Chief Minister was keen to reassure the Parliament that “the full letter of the law” would still be applied against acts of homicide, as the authorities would continue to distinguish between a self-evidently \textit{malicious} act and that of \textit{beneficent} AVE or PAS.\textsuperscript{12}

\textbf{The ROTTIA’s Second Reading – The Sanctity of Life and Human Rights Debate}

The parliamentary response to Perron’s Bill was occasionally hostile, with Stephen Hatton arguing that this ambiguously worded and “unclear” policy was being “rushed through with obscene haste”.\textsuperscript{13} Deputy Chief Minister Shane Stone expressed similar reservations about the reliability of the \textit{ROTTIA’s} proposed guidelines, suggesting that no matter how thorough legislative framers were in drafting and redrafting the Act, the legalisation of AVE and PAS would ultimately “debase the currency of human life”.\textsuperscript{14} Stone’s appraisal was endorsed by Neil Bell, having concluded that parliamentary support for the \textit{ROTTIA} would indeed send a utilitarian message that some lives are without value.\textsuperscript{15} It was prudent, therefore, to suggest that more extensive ‘mercy killing’ practices could eventuate \textit{if} expedient or greater good ends were seen to take precedence over consent in dying. In an attempt to offset any such potentiality, Richard Lim and Denis Burke maintained that the

\begin{itemize}
\item \textsuperscript{11} Northern Territory Government, \textit{Northern Territory Legislative Assembly – Rights of the Terminally Ill Bill (Serial 67)}, p.4
\item \textsuperscript{12} ibid., p.2
\item \textsuperscript{14} ibid., p.3671 & p.3673
\item \textsuperscript{15} ibid., p.3711
\end{itemize}
killing of innocent citizens must remain as a prohibited practice.¹⁶ To do otherwise would be at odds with the universal human rights commitment to protect personhood, as Michael Palmer insisted that there could be “no dignity in death”.¹⁷ In response, Marshall Perron counter-argued that the primary aim of the ROTTIA was, in fact, to preserve human dignity by reducing the “misery and suffering” of a carefully vetted group of citizens for whom palliative care provided “no comfort”.¹⁸ While Perron understood that life itself is not an intrinsic good irrespective of its circumstances, there was no indication that he favoured a strictly utilitarian end of life policy or had any desire to discount the indispensable right to life principle. In fact, the proposal that the Territory Parliament should support the legalisation of AVE and PAS in order to alleviate needless terminal suffering could well have been depicted as an implicit precondition for the self same good (i.e. dignified and compassionate treatment) that human rights conventions typically aspire to.

Religion and the Right to Die

Despite the fact that religious members of the Chamber tended to argue that their resistance to the ROTTIA was informed by pragmatic sanctity of life concerns rather than by purely faith based objections, several MP’s saw fit to invoke the separation of Church and State principle in order to ensure that the reform debate was determined on strictly secular grounds.¹⁹ The implication that ‘private’ theological beliefs should not have a defining influence on the ROTTIA debate was, nevertheless, difficult to sustain as the pursuit of

¹⁶ ibid., p.3720 & p.3635

¹⁷ ibid., p.3678

¹⁸ ibid., p.3731

¹⁹ ibid., p.3635, p.3684, p.3705, pp.3729–3730
power and the fulfilment of partisan interests are common political objectives. Conversely, a willingness to acknowledge that all citizens have a democratic right to pursue a diversity of views in public debate need not imply indifference toward the self regarding wishes of the constituent majority. It was reasonable, therefore, for Marshall Perron to remind his parliamentary colleagues that they had an overriding obligation to represent the policy objectives of the Territory’s predominantly pro-choice electorate. Noel Padgham-Purich predicted, nonetheless, that religious lobbyists would instinctively resist Perron’s ROTTIA legislation, given the clergy’s sensitivity to the fact that their “power over life and death” would be eroded if the Act gained legislative assent.  

John Bailey concurred that these typically conservative ideologues were likely to pull out all stops in order to offset any further “diminution” of religious authority in a self prescribed secular society.

It bears emphasis that Christian parliamentary responses to the ROTTIA were occasionally sympathetic with Catholic Loraine Braham conceding that rational individuals should have “freedom of choice” in end of life affairs. Barry Coulter also opted to part ways with the traditional theological prohibition against active euthanasia, having candidly asserted that “I simply do not subscribe to the views of the Roman Catholic Church” on the issue of AVE. The ‘moral momentum’ appeared to be very much with the pro-reform lobby, as the Church’s commitment to an arguably indefensible policy of “compel[ing] people to

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20 ibid., p.3641
21 ibid., p.3645
22 ibid., p.3654
23 ibid., pp.3657–3658
suffer” was aptly described by Richard Setter as “quite inhuman”. While a sceptic might have pondered whether Territory MPs had resolved against religious assertions in order to avoid alienating secular constituents, the fact remained that they were prepared to break ranks with more conservative elements from within the Church in favour of individual end of life choice and the minimisation of needless terminal suffering. This was significant, as the decision to reject a tradition of helpless determinism arguably demonstrated that religious politicians had come some way in recognising that the illiberal approach taken by some of their Christian colleagues was both erroneous and counter-productive. This expression of religious tolerance came at a price, however, as the ‘consistencies’ of established legal and moral tradition were to be traded-off for the comparative uncertainties of legislative reform.

**Slippery Slope Concerns**

In an attempt to alleviate concerns that the ROTTIA would inspire public ambivalence towards the sanctity of life ethic, Eric Poole stressed that there was “no compulsion” within the Act for anyone to participate in either an AVE or PAS procedure. It was further asserted that the ROTTIA need not result in an epidemic of active euthanasia terminations, as Phillip Mitchell advised the Chamber that just 2 per cent of all deaths in the (AVE permissive) Netherlands were active euthanasia related. Unfortunately, these assurances failed to allay Denis Burke’s sense of disquiet that once AVE and PAS were legalised, there would no longer be any grounds to deny Territory patients a termination

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24 ibid., p.3667
25 ibid., p.3726
26 ibid., p.3701
procedure for virtually any reason that they deemed fit.\textsuperscript{27} For instance, evidence had already come to light that the Netherlands had gone beyond previously envisaged legislative parameters by accommodating a right to die request of a patient who was suffering from chronic depression.\textsuperscript{28} The Northern Territory was not exempt from this type of advancing policy, as Michael Palmer alleged that there had been a historic propensity on the part of the Courts to push the boundaries of legislation.\textsuperscript{29} Aside from this issue of ‘legislative creep’, physician turned parliamentarian Richard Lim claimed that it was simply “not possible to trust doctors” with the “profound responsibility” of active euthanasia, as some members of the profession were a law unto themselves and would tend to ignore statutory requirements in order to satisfy their own objectives.\textsuperscript{30} In light of these concerns, Terence McCarthy concluded that it was “simply too fearsome” for the Territory to entertain the purportedly dubious idea of legalised AVE and PAS.\textsuperscript{31} Indeed, the President of the Northern Territory Branch of the Australian Medical Association (AMA), Dr. Chris Wake, affirmed that any decision to validate these practices would invariably undermine the security of vulnerable (elderly, disabled, and high dependency) patients.\textsuperscript{32}

Marshall Perron endeavoured to draw attention away from arguably alarmist slippery slope predictions, having remarked that (illegal) active terminations were already being carried

\begin{itemize}
\item \textsuperscript{27} ibid., p.3634
\item \textsuperscript{28} ibid., p.3676
\item \textsuperscript{29} ibid., p.3677
\item \textsuperscript{30} ibid., p.3722
\item \textsuperscript{31} ibid., p.3731
\item \textsuperscript{32} C Wake, “I Refuse to Kill You”, \textit{Asian Wall Street Journal}, 18 July 1996, p.6
\end{itemize}
out “everyday” by Australian medical practitioners. Medical surveys backed-up Perron’s assertion, with evidence to suggest that around 30 per cent of Australian doctors had taken deliberate steps to bring about the death of a petitioning terminal patient. While there was no suggestion that this clandestine culture had led to widespread euthanasia abuses, Perron affirmed that the ROTTIA would help ensure public accountability for end of life procedures by ending the “code of silence” that had, until now, been tolerated. Indeed, Perron was well aware that the dedication of his political counterparts to oppose the ROTTIA was not reflected in their ambivalence about the current law’s inability to monitor clandestine (AVE) terminations. Aside from the fact that it made better sense to expose these practices to public scrutiny, Perron asserted that the Act’s strict commitment to “respect…human freedom and autonomy” meant that predictions about inappropriate non-voluntary and involuntary killings were unlikely to eventuate. In fact, there was “no doubt” in Perron’s mind that “adequate safeguards” could be set in place to ensure that active euthanasia remained a distinctly “patient driven” initiative. In spite of his own in principle opposition to AVE, Attorney General Denis Burke ultimately agreed with Perron that the proposed ROTTIA appeared to have satisfied this duty of care objective.

36 Northern Territory Government, Northern Territory Legislative Assembly – Rights of the Terminally Ill Bill (Serial 67), p.6
37 M Perron, “We have a Right to Die”, Asian Wall Street Journal, 18 July 1996, p.6
38 D Conway, “It’s Murder or Suicide, says Church”, Daily Telegraph, 27 September 1996, p.4
The Issue of Individual Liberty

The Territory’s parliamentary ROTTIA supporters were understandably keen to emphasise the Act’s ethical underpinnings, with Frederick Finch observing that the ROTTIA was an acknowledgment of the right of all citizens “to exercise their [free] will”, because “Nothing” is “more fundamental in this life than a person’s individual rights”.

Finch’s argument was clearly influenced by the core liberal assumption that the right to remain sovereign over one’s existence and, indeed, demise was central to the idea of personhood. The mere assertion of a right on grounds of a contested ‘self regarding’ (choice in dying) thesis was, nevertheless, unconvincing for those who viewed AVE as very much an ‘other regarding’ undertaking. Indeed, Sydney Stirling took issue with the concept of a self regarding right to die, having asserted that “selfishness” ultimately underpinned ROTTIA advocates’ alleged lack of regard for the interests of vulnerable others.

Shane Stone concurred that pro-choice lobbyists should, ideally, be prepared to put aside their own immediate individual interests in order to ensure “the overall good of society”. If Parliament were to proceed to vindicate choice in dying, then Stone speculated that the authorities would also have to consider the legalisation and “sale of heroin” or allow people to “mutilate themselves” without interference.

This arguably extreme comparison did not aid the anti-ROTTIA case, however, as no one could reasonably compare beneficent AVE with drug abuse or other forms of irrational self harm. While there was no question that the risks associated with untrammelled individualism would always need to be considered, it bears emphasis that the Territory Parliament’s right to die exponents had no


40 ibid., p.3627

41 ibid., pp.3673–3674
desire to encourage irresponsible views or practices to the detriment of legitimate individual or collective (end of life) interests.

The Role of Territory Representatives

In light of a conviction that paternal intervention was only warranted in order to discourage euthanasia abuses, Noel Padgham-Purich maintained that those Territory MPs who were intent on voting against the well established pro-AVE views of Territory constituents ought to “think again about whether they should continue as politicians”.\(^{42}\) A somewhat more conciliatory note was struck by Marshall Perron who invited these members to take the opportunity to “absent themselves” from the ROTTIA vote.\(^{43}\) As an opponent of the ROTTIA, Michael Palmer mounted a liberal–communitarian argument that a politician’s oath to “render true and faithful service” to their constituents meant that they were duty bound to follow their “personal ethics and conscience” in pursuit of the public good.\(^{44}\) Shane Stone encapsulated the thrust of Palmer’s trustee representative interpretation when he too reminded the Legislative Assembly that “No one…has the right to tell you how to vote when a conscience vote is permitted”.\(^{45}\) Whilst Stone maintained that a politician should always take the opinions of their constituents into account, these views were not “definitive” for each parliamentary member must ultimately draw their own conclusions in

\(^{42}\) ibid., p.3638 & p.3642

\(^{43}\) ibid., p.3733

\(^{44}\) ibid., pp.3678–3679

contentious policy affairs.\textsuperscript{46} Toward that end, Marshall Perron advised that he would tender his resignation as Chief Minister on the morning of the Bill’s second reading so as to offset any suggestion that Party colleagues had been pressured to lodge a ‘conscience vote’ in support of the \textit{ROTTIA}.\textsuperscript{47} Admittedly, this initiative was of little consolation to those critics who maintained that most Territory residents who supported a right to die option had failed to differentiate between an active termination and that of the more conventional practice of allowing patients to die.\textsuperscript{48} In addition to the claim that the public misunderstood the scope of the \textit{ROTTIA}, questions were also raised about the fallibility of (Territory) politicians. In an attempt to allay these concerns, the Territory Parliament sought to consult with the community on the \textit{ROTTIA} issue by extending an invitation for written public submissions to a parliamentary endorsed Select Committee.\textsuperscript{49}

\textbf{The \textit{ROTTIA} Bill’s Referral to a Select Committee – Indigenous Concerns}

The Select Committee’s report, entitled \textit{The Rights of the Individual or the Common Good}, was presented to the Territory Assembly on 16 May 1995.\textsuperscript{50} Amongst the most significant findings was that the \textit{ROTTIA} would have a detrimental influence on the readiness of

\textsuperscript{46} ibid.

\textsuperscript{47} M Cosic, \textit{The Right to Die? – An Examination of the Euthanasia Debate}, New Holland, Sydney, 2003, p.170


\textsuperscript{49} N Cameron, “Euthanasia Legislation in the Northern Territory – The Right of the Individual or the Rights of Society?”, \textit{Northern Perspective}, Vol.19, No.1, 1996, p.91

\textsuperscript{50} Northern Territory Government, \textit{Legislative Assembly of the Northern Territory: The Right of the Individual or the Common Good Volume One – Report of the Inquiry by the Select Committee on Euthanasia}, Government Printer of the Northern Territory, 1995, p.vi
Indigenous citizens to attend hospitals or medical clinics.\textsuperscript{51} More specifically, Father Joe Brady of Santa Teresa in Central Australia observed that while local Aboriginals were in the habit of visiting physicians and specialists as the need arose, they frequently did so in a spirit of trepidation.\textsuperscript{52} If the \textit{ROTTIA} were to be implemented, then it was alleged that some Aboriginal people would consciously avoid attending medical clinics for fear of being arbitrarily killed by a lethal injection.\textsuperscript{53} As a consequence, potentially life threatening health complications would be left untreated while important inoculations would also be missed.\textsuperscript{54}

While Marshall Perron insisted that the AMA had deliberately fostered a “dishonest” campaign designed to encourage Indigenous discontent, Doctors Concerned about Euthanasia maintained that the predicted attendance boycott had arisen primarily because the Government had failed to adequately consult with Aboriginal people on the specifics of the \textit{ROTTIA}.\textsuperscript{55} The AMA’s Chris Wake affirmed that much of the blame for Indigenous unrest could be laid at the feet of Marshall Perron who, it was alleged, had “purposefully set about disenfranchising…Aboriginal Communities from [the \textit{ROTTIA}] debate”.\textsuperscript{56} This allegation was not entirely convincing, however, as Perron and his Party allies would surely have recognised that an aggrieved Indigenous community (representing a quarter of the Territory population) could have influenced the outcome of the next election.

\begin{itemize}
\item \textsuperscript{51} ibid., p.viii
\item \textsuperscript{52} ibid., p.14
\item \textsuperscript{53} ibid., p.13
\item \textsuperscript{56} Wake, op.cit., p.6
\end{itemize}
Moreover, there was obviously little to be gained on the part of a ‘negligent’ government by inviting negative Select Committee publicity in relation to the sensitive matter of Indigenous welfare.

Despite Government assurances that Indigenous interests would be protected, it was clear that a more extensive consultation process was needed to discourage threats of violent reprisal upon euthanasia providers. The member for Arnhem, John Ah Kit, advised the Parliament that retaliation in response to an Aboriginal termination would typically be enacted “very quickly” as “traditional law takes first place” over the laws of the State. Indeed, it was explained that customary Aboriginals would tend to view the ‘euthanasia needle’ as the tool of a sorcerer and the physician as an agent of destruction. As the sitting representative for eight major Indigenous communities, Maurice Rioli affirmed that the combined impact of customary beliefs and the proliferation of misinformation had ensured “overwhelming” Aboriginal opposition to the ROTTIA. Rather than simply dismissing the Act as unworkable, the parliamentary Select Committee recommended that Indigenous communities would need to be suitably reassured about the ROTTIA’s objectives and its strictly defined and enforced limitations. This recommendation was not only embraced by the Act’s parliamentary supporters as a social justice imperative, but it was also a clear

57 Northern Territory Government, Legislative Assembly of the Northern Territory: The Right of the Individual or the Common Good Volume One, p.26


60 Northern Territory Government, Legislative Assembly of the Northern Territory: The Right of the Individual or the Common Good Volume One, p.26
affirmation that *unfounded* minority misgivings should not be permitted to stand in the way of the democratic pro-reform wishes of the majority of the Territory population.\textsuperscript{61}

**Palliative Care Shortfalls**

Aside from concerns raised in relation to the Indigenous community, the Select Committee report also challenged the credibility of the *ROTTIA*’s last resort provisions, having found that palliative care services were scarce and manifestly inadequate to satisfy the demands of the Territory population.\textsuperscript{62} While this problem had been exacerbated by the impracticalities of dealing with a widely dispersed and often remote citizenry, the lack of a dedicated palliative care unit or hospice meant that the Territory’s acute terminal illness services were being provided in an unacceptably haphazard fashion.\textsuperscript{63} Additional submissions from concerned Territory physicians also indicated that the care of terminal patients was being further undermined by the difficulty in acquiring “adequate supplies of appropriate drugs”.\textsuperscript{64} In light of these serious administrative failings, the AMA’s Federal President Dr. Brendan Nelson had written to Chief Minister Perron to remind him that “Governments have an obligation to see [that palliative] care services are well funded and [adequately] resourced”.\textsuperscript{65} The Northern Territory Branch of the AMA, in conjunction with

\textsuperscript{61} Northern Territory Government, Hansard and Legislation, 24 May 1995, p.3727

\textsuperscript{62} Northern Territory Government, *Legislative Assembly of the Northern Territory: The Right of the Individual or the Common Good Volume One*, p.viii. See further Woodruff, op.cit., p.10


\textsuperscript{64} ibid., p.31

some independent practitioner submissions, concluded that the Administration’s proposed “quick fix” euthanasia solution to unmanaged suffering was an inappropriate response to a palliative care resource shortfall.\textsuperscript{66} Moreover, the Select Committee observed that the introduction of the ROTTIA might, in fact, further exacerbate existing problems with financially constrained healthcare administrators viewing AVE and PAS options as an opportunity to redirect funding away from this already under-resourced terminal care sector.\textsuperscript{67} While there can be no disputing that the Territory Government had a duty of care to ensure that these resource deficiencies were redressed, this was not a solution in and of itself, as it has been repeatedly affirmed throughout this thesis that even the best of palliative care is sometimes insufficient to satisfactorily alleviate extreme forms of terminal distress. While this concession is in no way intended to trivialise or negate the indispensability of optimal palliative care, this (Northern Territory) case study highlights the importance of ensuring that AVE and PAS provisions are genuine last resort options.

**The Church’s Response to the ROTTIA**

It was soon apparent that no matter what the Territory Administration did to rectify palliative care shortcomings there was no room for compromise on the issue of AVE or PAS on the part of the mainstream clergy. For example, the Anglican Primate of Australia, Dr. Keith Rayner, advised that the National Council of Churches (representing the


\textsuperscript{67} Northern Territory Government, *Legislative Assembly of the Northern Territory: The Right of the Individual or the Common Good Volume One*, p.17
Anglican, Roman Catholic, Uniting, Greek Orthodox, Churches of Christ and various other denominations) viewed intentional mercy killing as “contrary to God’s law and the values of a civilized society”. At a local level, the Northern Territory Council of Churches (comprising “90 per cent of all practicing Christians in the Northern Territory”) also rallied against the ROTTIA alleging that legalised AVE and PAS would undermine care and support for the dying. While the General Secretary of the Uniting Church Board for Social Responsibility went out on a limb in conceding that there were occasions when AVE might be an “appropriate” response to intolerable suffering, the Board was clearly out of step with the Territory’s Northern Synod which contrastingly asserted that a society which can no longer “guarantee life…cannot be expected to guarantee any of the freedoms that flow from such a guarantee”. In fact, Churches from across the entire country reiterated that the ‘selfish individualism’ that was allegedly driving the ROTTIA proposal would ultimately undermine the whole fabric of Territory society.

While the Church’s commitment to defend the communal good was not without merit, it was ultimately based upon a contentious assumption that corrupt behaviour must follow on from an acknowledgment of individual choice in dying. Indeed, it has been asserted in earlier chapters of this thesis that this worst case scenario is only likely to eventuate if society chooses to ignore the fact that we are interdependent social beings with rights and

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68 Senate Legal and Constitutional Legislation Committee, op.cit., p.68 [6:47]


responsibilities or alternatively, persists with the potentially problematic (liberal) notion that morality is an inherently subjective and fluid ideal.\footnote{See, for example, Chapter Four’s discussion on moral ambiguity and Chapter Five’s communitarian analysis of AVE reform.} Although it is not out of the question that either eventuality could corrupt an otherwise credible end of life policy, it still cannot be overlooked that the not negotiable approach to the ROTTIA debate taken by a number of Church representatives was often strong on rhetoric and lacking in insight. For instance, Australia’s most senior Catholic leader, Cardinal Edward Clancy, described the ROTTIA’s active (voluntary) euthanasia provision as akin to legalising the act of “murder” despite the fact that the proposed Act was plainly beneficent in scope.\footnote{“The Euthanasia Divide”, op.cit., p.1. See further Editorial, “Catholic Church backs Anti-euthanasia Bill”, Daily Telegraph, 5 September 1996, p.20}

Unfortunately for the Church, the invocation of evocative terminology and slippery slope predictions were not enough to convince the majority of Territory MPs of the alleged impropriety of the ROTTIA. On the contrary, as Marshall Perron and his parliamentary supporters refused to submit to ecclesiastical dictates on grounds that a secular Government should not be imposed upon to “enshrine” a “religious point of view”.\footnote{Northern Territory Government, Northern Territory Legislative Assembly – Rights of the Terminally Ill Bill (Serial 67), p.5} While it has previously been argued (in Chapter Six) that religious policy objectives should not be singled out for exclusion from the democratic political arena, it was difficult to find fault with Perron’s assertion that even if the Territory’s entire church-going population opposed the ROTTIA, this would not be sufficient basis to ignore the pro-choice wishes of the majority of non-churchied citizens.\footnote{ibid.} The Voluntary Euthanasia Society fully concurred
with Perron that an unrepresentative “theological stand…should not be foisted on those who do not share the faith from which it is derived”.76 If a terminal patient desired last resort AVE or PAS in alleged contravention of religious doctrine, then it could be legitimately argued that it was their ‘God-given’ liberal–democratic right to do so. This concession did not preclude the right to counsel against end of life undertakings, only that it is not the place of a person of faith (or of no faith) to define for another (rational) individual what is and what is not an acceptable self regarding activity.

Secular Submissions Opposing the ROTTIA Bill

Paternal assertions were not the sole domain of religious commentators, as secular right to life lobbyists insisted that Marshall Perron’s emotive response to terminal suffering had clouded his ability to appreciate the potentially dire consequences of State sanctioned (active) euthanasia.77 More specifically, the Australian Federation of Right to Life Associations claimed that if the ROTTIA were passed, it would invariably lead to “a significant number of patients” being terminated without their express permission.78 Right to Life Chairperson Margaret Tighe suggested that the ROTTIA would, in fact, make the Territory a veritable “Mecca for patient killing”.79 The former Director of Sydney University’s Palliative Care Teaching Hospital, Brian Pollard, explained that the “inviolability of innocent human life” and the “right of every individual” to have that life

76 Northern Territory Government, Legislative Assembly of the Northern Territory: The Right of the Individual or the Common Good Volume Three: (001–304), p.163 [061]

77 Northern Territory Government, Northern Territory Legislative Assembly – Rights of the Terminally Ill Bill (Serial 67), pp.4–5. See further Northern Territory Government, Legislative Assembly of the Northern Territory: The Right of the Individual or the Common Good Volume Three: (001–304), p.174 [067]

78 ibid., p.204 [091A]

“protected” could only be assured if the “unethical” practice of AVE remained illegal.\(^{80}\) Indeed, it was pointed out that English speaking Parliaments throughout the world had consistently opposed the legalisation of active euthanasia on the same grounds that it was allegedly impossible to guarantee that end of life abuses would not occur.\(^{81}\) AMA Federal President Dr. Brendan Nelson added weight to this contention, maintaining that if the \textit{ROTTIA} was adopted, “a degree of informality” would “likely” arise amongst those more liberal elements of the profession who were willing to act as euthanasia providers, and that this would lead to “dangerous shortcomings” in the Territory’s capacity to police and control patient terminations.\(^{82}\)

In light of assurances that “the majority” of medical practitioners were philosophically opposed to the legalisation of mercy killing, the prevailing \textit{Natural Death Act (1988)} was touted as providing a preferred ‘solution’ to intolerable terminal suffering, because it allowed for “the withdrawal of life support and the refusal of extraordinary or burdensome treatments”.\(^{83}\) It was somewhat damning, therefore, that the Select Committee reported that there was “very little awareness” amongst the Territory population of this particular Act’s provisions.\(^{84}\) \textit{ROTTIA} supporters were, nonetheless, mindful that the \textit{Natural Death Act} provided a less than satisfactory option for those patients who desired a swift and easeful

\begin{itemize}
  \item \textit{Northern Territory Government, Legislative Assembly of the Northern Territory: The Right of the Individual or the Common Good Volume Three: (001–304)}, pp.207–208\(^{[093]}\)
  \item ibid., p.211\(^{[093]}\)
  \item \textit{Northern Territory Government, Legislative Assembly of the Northern Territory: The Right of the Individual or the Common Good Volume Three: (665–915)}, p.71\(^{[673]}\)
  \item ibid., p.65\(^{[673]}\). See further \textit{Northern Territory Government, Legislative Assembly of the Northern Territory: The Right of the Individual or the Common Good Volume Three: (305–664)}, p.170\(^{[483]}\)
  \item \textit{Northern Territory Government, Legislative Assembly of the Northern Territory: The Right of the Individual or the Common Good Volume One}, p.viii & p.32
\end{itemize}
death, as opposed to a more prolonged and less predictable dying process. As such, Marshall Perron specifically singled out the AMA’s “patronising stance” against much needed euthanasia reform as contrary to terminal patient interests.\textsuperscript{85} The Chief Minister was supported by leading reform advocate Dr. Philip Nitschke, who argued that the medical association’s anti-\textit{ROTTIA} agenda was unacceptably dictatorial.\textsuperscript{86} While there was no suggestion that measures designed to protect the interests of patients and physicians were unnecessary, there was a clear consensus amongst \textit{ROTTIA} supporters that attempts to deny complicit individuals the right to follow their own conscience in the initiation of beneficent last resort AVE or PAS were excessive and unjust.

\textbf{Parliamentary Opposition to the \textit{ROTTIA}}

Despite last minute pro-life lobbying, the \textit{ROTTIA} was passed on 25 May 1995 in the Territory’s 25 member (single Chamber) Parliament by the barest majority—13 in favour, 12 against.\textsuperscript{87} Neil Bell, subsequently, predicted that the Territory’s “already overstretched public health system” would now be subjected to “intolerable” pressure, as people would come from all over Australia to avail themselves of legalised active euthanasia.\textsuperscript{88} Other expressions of disquiet were raised by Peter Adamson, who predicted that vulnerable patients would invariably begin to “fall through” the Act’s safety net.\textsuperscript{89} In response to these grievances, a minority of parliamentary members were unsuccessful in their bid to disallow

\textsuperscript{85} S Dow, “Perron Blasts AMA on Mercy Killing”, \textit{Age}, 23 August 1995, p.6

\textsuperscript{86} P Nitschke, “Euthanasia: The Right to Choose”, \textit{Australian Rationalist}, No.58–59, p.18

\textsuperscript{87} ibid., p.16

\textsuperscript{88} Northern Territory Government, \textit{Legislative Assembly Parliamentary Record – Seventh Assembly, First Session: 20–22 February, 1996}, p.6370 [20 February]

\textsuperscript{89} ibid., p.6400 [20 February]
the ROTTIA under the guise of The Respect for Human Life Bill.\textsuperscript{90} John Ah Kit’s subsequent proposal that a ‘sunset clause’ enabling the Territory Parliament to “monitor and review the legislation…until 1 July 1999”, and to then discontinue the ROTTIA if it had proved to be “unworkable”—was also rejected.\textsuperscript{91} Such was the iron-clad resolve of the ROTTIA’s parliamentary majority that an attempt by Eric Poole to deny public hospitals and health clinics the right to provide assistance under the Act proved equally unsuccessful.\textsuperscript{92}

\textbf{A Legal Challenge against the ROTTIA}

In light of failed parliamentary initiatives designed to limit or invalidate the ROTTIA, Supreme Court proceedings were launched by Reverend Djiniyini Gondarra and the Northern Territory AMA President, Dr. Chris Wake.\textsuperscript{93} These proceedings were initiated on the basis that “the [Territory] Administrator had not validly given his assent to the Act”, as the ROTTIA had been passed without reference to the Commonwealth Governor-General.\textsuperscript{94} This claim sharply contrasted with the Senate Legal and Constitutional Legislation Committee’s assertion that the Northern Territory possessed the required independent authority to introduce the ROTTIA and that the Act had, in fact, been “validly enacted”.\textsuperscript{95} A 2 to 1 Supreme Court majority confirmed on 24 July that the Administrator had indeed

\textsuperscript{90} ibid., p.6366 [20 February]

\textsuperscript{91} ibid., p.6425 [20 February]

\textsuperscript{92} Senate Legal and Constitutional Legislation Committee, op.cit., p.8 [2:20]

\textsuperscript{93} ibid., p.8 [2:21]

\textsuperscript{94} ibid., p.9 [2:22-25]

\textsuperscript{95} ibid., p.10 [2:32]
behaved legitimately, as the Territory authorities had a right to implement legislation regarding the “maintenance of law and order and the administration of justice, private law” and the “regulation of…professions”.

The Supreme Court was also required to address a further submission alleging that it was beyond the jurisdiction of government to legislate against the inalienable right to life. In response, Justice Angel maintained that an Act designed to institutionalize intentional (active euthanasia) killing was entirely unique and demonstrated “no relevant substantial connection with any or any combination of the heads of power” as outlined in section four of the Territory’s self-government regulations.

Although Angel’s assertion (that valid assent had not been acquired) conflicted with the views of the majority of the Bench, the Court was not about to confirm that Territory or Commonwealth common or statutory law supported an “inalienable right to life”. In ruling against the plaintiffs, Justice Martin and Justice Mildren conceded that the ‘right to life’ could, under certain circumstances, be legitimately abrogated by Parliament.

Outline of the ROTTIA Legislation

After some 13 months of intense scrutiny and legal challenges, the ROTTIA eventually came into operation on 1 July 1996. The Act permitted a “medically qualified person” to

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96 ibid., p.9 [2:26]
97 ibid., p.8 [2:22]
98 ibid., p.9 [2:27]
100 ibid., pp.9–10
legally assist in ending the life of an eligible terminally ill adult (18 years and over) at their express request.\textsuperscript{102} It was further stipulated that the assisting medical practitioner must be a bona-fide physician who has continuously practiced medicine in Australia for not less than five years. The core term ‘assist’ was defined in the following manner:

\begin{quote}
the prescribing of a substance, the preparation of a substance and the giving of a substance to the patient for self administration, and the administration of a substance to the patient.\textsuperscript{103}
\end{quote}

Terminal illness was confined to a condition which in accordance with “reasonable medical judgement” and in the absence of “extraordinary measures” or treatment is “unacceptable to the patient” and would normally result in their death.\textsuperscript{104} Individuals who satisfied each of these criteria and who believed that their “pain, suffering and/or distress” had reached “unacceptable” levels were, thus, eligible to have their life legally terminated.\textsuperscript{105}

Critics were right to point out however, that the \textit{ROTTIA’s} terminal illness clause was much too broad as it could conceivably include medically manageable conditions such as diabetes or coronary artery disease.\textsuperscript{106} If a patient with either of these life threatening illnesses concluded that their quality of life and medical treatment was unacceptable, then

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\textsuperscript{103} ibid., p.2 [Section 3]

\textsuperscript{104} ibid.

\textsuperscript{105} ibid., p.2 [Section 4]

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it was theoretically permissible for them to apply for a termination under the Act. While it appeared unlikely that an otherwise well managed diabetic would be appraised as having a legitimate claim for an AVE or PAS termination, this administrative loophole served to highlight the difficulties that Territory legislators had been confronted with in drafting legislation that was sufficiently broad to cater for genuine last resort cases, yet strict enough to exclude more ‘frivolous’ claims. This was precisely why practitioners had to be satisfied firstly, that the patient’s terminal illness was causing “severe pain or suffering” and secondly, that they had considered other “reasonably available” medical alternatives.

Although it is clear that the term ‘reasonably available’ was itself ambiguous and in need of further clarification if the Territory authorities were to satisfy their duty of care to ensure that a patient’s palliative care interests were adequately protected, other ROTTIA safeguards were more explicit.

The Territory Act stipulated that an evaluating physician was required to ensure that a patient was of “sound mind” and not suffering from “treatable clinical depression” and that their termination request had, indeed, been a carefully considered rational decision that involved due consideration for their own needs, and, for the possible distress that their orchestrated death may cause for their family. Unfortunately, the ROTTIA did not specifically rule out an AVE or PAS request on the part of a patient who was suffering

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107 D Van Gend, “Euthanasia’s Unproductive Burdens”, Quadrant, January–February 1997, p.16


109 Keown, op.cit., pp.159–160

110 Northern Territory Government, Rights of the Terminally Ill Act 1995, p.4 [Section 7:1:C:IV & Section 7:1:G–H]
from ‘untreatable’ depression or a non-depression related disorder, such as anxiety.\textsuperscript{111} Nor was there any requirement for a patient’s existential distress to be addressed prior to their termination.\textsuperscript{112} While it was anticipated that physicians would recognise the importance of ensuring that the patient was capable of comprehending the magnitude and finality of their request, it was clearly not the practitioner’s role to \textit{resolve} a candidate’s deep-seated emotional anxieties about the meaning of life and/or human suffering. Provision should, therefore, have been made for mandatory counselling to ensure that patients were screened for maladies that went beyond treatable clinical depression. Indeed, failure to investigate a patient’s existential angst, for example, would not only have been a dereliction of reasonable care but it would also have brought into question the ROTTIA’s crucial last resort status.

On the other side of the ledger, the Territory Government’s desire to limit the liability of doctors was reflected in the Act’s stipulation that physicians could refuse to participate in PAS or AVE for “any reason” whatever.\textsuperscript{113} In fact, it was illegal to offer a bribe or to otherwise threaten a physician in order to ensure their compliance in an end of life procedure.\textsuperscript{114} In alternate cases where a \textit{consenting} physician confirmed a patient’s eligibility for AVE or PAS, there was a provisional requirement for a second medical practitioner who “holds a diploma of psychological medicine or its equivalent” and who was “not a relative or employee of, or a member of the same medical practice”, to be called

\textsuperscript{111} Keown, op.cit., p.160

\textsuperscript{112} Collins & Brennan, op.cit., pp.1907–1908

\textsuperscript{113} Northern Territory Government, \textit{Rights of the Terminally Ill Act 1995}, p.2 [Section 5]

\textsuperscript{114} ibid., p.3 [Section 6:1]
upon to corroborate their colleague’s evaluation.\textsuperscript{115} Once a medical consensus had been established, a pause in official proceedings would then take effect in order to provide the patient with the opportunity for reflection. In particular, a minimum seven days must have lapsed after the patient’s initial (verbal) AVE or PAS request before formal documentation could be completed and submitted.\textsuperscript{116} This process required that the patient or their authorised proxy (who for obvious reasons needed to forfeit “any financial or other benefit” resulting from the candidate’s death) sign a “Certificate of Request” in the presence of the participating medical practitioner and one other physician.\textsuperscript{117} The Act further stipulated that each of these presiding physicians had to be certain that neither they nor their colleague stood to “gain a financial or other advantage” from the patient’s pending termination.\textsuperscript{118} In providing an additional safeguard against an imposed compliance, the ROTTIA advised that persons found to have improperly procured the signature of a patient (or witness) would face a fine of $20 000 or four years gaol.\textsuperscript{119} The risk of a language inspired misunderstanding was also addressed, as patients who did not share the same tongue as their physician(s) were to be provided with a senior (level three accredited) interpreter throughout the end of life process.\textsuperscript{120}
Not less than 48 hours after ROTTIA eligibility criteria had been met and the Certificate of Request was completed, the designated medical practitioner was permitted to proceed with the PAS or AVE termination.\textsuperscript{121} At “any time” during these proceedings, the patient retained the right to rescind their end of life application “in any manner” that they deemed fit.\textsuperscript{122} In cases where the patient expressed a change of heart, the participating physician was then—“as soon as practicable”—required to “destroy the Certificate of Request and [to] note that fact on the patient’s medical record”.\textsuperscript{123} In other instances where a termination went ahead, the Act required that the physician retain a copy of the patient’s written end of life request, a documented commentary confirming that the deceased party had met ROTTIA criteria, and details of the drugs that were prescribed.\textsuperscript{124} The physician was also bound to notify the Coroner of the patient’s death by forwarding a completed copy of the death certificate. As long as they had fully complied with these guidelines, participating physicians remained exempt from “civil or criminal action or professional disciplinary action”.\textsuperscript{125} All things being equal, it was anticipated that the Coroner’s only other role would be to inform the Attorney General of the annual number of patients whose lives had been legally terminated under the Act.\textsuperscript{126}

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\textsuperscript{121} ibid., p.5 [Section 7:1N–P]
\textsuperscript{122} ibid., p.6 [Section 10:1]
\textsuperscript{123} ibid., p.6 [Section 10:2]
\textsuperscript{124} ibid., p.7 [Section 12]
\textsuperscript{125} ibid., p.9 [Section 20:1]
\textsuperscript{126} ibid., p.8 [Section 14:2]
\end{flushleft}
The *ROTTIA* in Practice

The first patient to die under the *ROTTIA*’s world first provisions was 66 year old prostate cancer sufferer Bob Dent. The day immediately prior to his induced death (on September 22 1996) Dent composed an open letter which stated in no uncertain terms that “If you don’t agree with voluntary euthanasia then don’t use it, but don’t deny me the right to use it if and when I want to.”

Dent explained that he had lived with cancer for five years and during that time had undergone a series of surgical procedures which—amongst other indignities—included the removal of his testicles. Since that time, life had progressively deteriorated into “a roller-coaster of pain” with broken and painful bones, nausea and diarrhoea. It was readily apparent that all that remained in Dent’s future was the distressing prospect of the cancer spreading even further through his already ravaged body.

In the interim, Dent was reliant upon 24 hour nursing care and required a rubber sheet on his bed in case of an uncontrollable bowel movement. This intolerable state of affairs had purportedly brought Dent to the point where he would have gladly “blown” his “head off”, had he had a gun to do so. In spite of this patient’s evident physical and emotional distress, a mandatory psychiatric evaluation found Dent to be “an intelligent and sensitive man [who was] fully aware of all the issues concerning him and his illness”.

In light of Dent’s confirmed eligibility for an AVE or PAS termination, mechanisms were set in place to fulfil the patient’s final wish. In particular, Dr. Philip Nitschke’s purpose

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127 Nitschke, op.cit., p.19

128 Cosic, op.cit., p.181

129 ibid.

130 “The Euthanasia Divide”, op.cit., p.1
built Deliverance Machine was engaged in order for Dent to be connected to a Nembutal filled syringe which, in turn, was linked to a laptop computer. This lethal drug would be delivered directly into the patient’s vein only after Dent responded ‘yes’ to three specific computer prompts about his desire to receive this life-ending substance.\textsuperscript{131} Nitschke, who claimed to have experienced a sense of “excitement” and “exhilaration” when the \textit{ROTTIA} was passed into law, maintained that he had “no qualms” about his role in this physician-assisted suicide procedure, and would have personally ended Dent’s life but did not do so because he thought “it was better” if the patient “ran the show himself”.\textsuperscript{132} Indeed, Nitschke concluded that it is not the role of a physician “to be the one holding the syringe” if the patient is capable of doing so.\textsuperscript{133} Following Dent’s affirmative computer tabulations, Nitschke observed that the Deliverance Machine set in train a “fast acting” cocktail of “barbiturate and…muscle relaxant” which served to end the patient’s life within a “few minutes”.\textsuperscript{134}

The AMA Federal President Dr. Keith Woollard responded to Dent’s passing with a re-affirmation of the Association’s policy—“We do not believe that it is safe for society to have a bill in place that allows doctors to kill people.”\textsuperscript{135} A different yet equally critical perspective was offered by the Chairperson for the Victorian Association for Hospice and Palliative Care, Margaret O’Connor, having observed that “If I had been Bob Dent’s nurse,


\textsuperscript{132} ibid., p.32. See further Nitschke, op.cit., p.19

\textsuperscript{133} Nitschke & Stewart, op.cit., pp.74–75

\textsuperscript{134} Nitschke, op.cit., p.19

I would have been ashamed” because by the patient’s own account, he had not been receiving *optimal* palliative care. On behalf of the Church, Archbishop Cardinal Clancy similarly concluded that the alleged failure of Territory authorities to provide adequate medical care ensured that Dent’s “deplorable” death was “a shameful day for Australia”. While these criticisms were arguably well intentioned, they demonstrated an unwillingness to accept that the patient had made his own decision and that, not without due consideration for other alternatives. When all was said and done, it was evident that Dent’s poor or non-existent quality of life, sense of indignity and hopelessness made last resort PAS a credible undertaking. Unlike his critics, Dent recognised the importance of tolerance for the self regarding choices of others, and was not about to be dictated to by a bevy of strangers who were affronted by an action that ultimately had no bearing on their own lives.

The Dent affair and the subsequent outcry from the medical profession and pro-life lobbyists, failed to diminish Philip Nitschke’s determination to reinstate his purpose built suicide device in the service of 52 year old South Australian resident Janet Mills. Mills was suffering from a rare form of disfiguring cancer (mycosis fungoides) that systematically destroyed the skin, leaving it open to infections and perpetual irritation. The patient’s oncologist had advised that active management of her condition was no longer possible with death typically anticipated within about nine months. While Mill’s pain was

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137 Birch, op.cit., p.1

138 Cosic, op.cit., p.182

effectively managed her cancer related suffering persisted, with unrelenting pruritus (or an itch sensation) causing blistering, infection, and an unsightly discharge. Mill concluded that her situation was utterly “hopeless” and that she simply could not endure this cancerous burden any longer. Nitschke would later report that Mill’s induced death (on 2 January 1997) in the presence of members of her family was, under the circumstances, “as good as it gets”. Some 18 days later, a 69 year old Darwin male with terminal stomach cancer and identified only as ‘Bill X’ self-administered a lethal dose of prepared drugs whilst in the presence of Nitschke. According to Nitschke, “Bill wanted to die” because his life had become “a misery” of “untreatable” terminal symptoms, including pain, nausea, and vomiting. Indeed, the opportunity for ‘Bill X’ and Janet Mills to bring a painless end to their distressing lives highlighted the importance of the Territory authorities being in a position to ensure that a minimum duty of care was adhered to in the facilitation of legitimate end of life undertakings.

Following a trip from Sydney to Darwin a 70 year old breast cancer sufferer known as ‘Valerie’ became the final and arguably the most controversial candidate to die under the ROTTIA, after having availed herself of Nitschke’s Deliverance Machine technology. Despite evidence of “extensive metastatic disease”, Valerie had earlier conceded that she

140 Kissane et al., op.cit., pp.1099–1100

141 ibid., p.1100

142 Nitschke & Stewart, op.cit., p.121

143 Senate Legal and Constitutional Legislation Committee, op.cit., p.11 [2:37]

144 Nitschke & Stewart, op.cit., p.85. See further Kissane et al., op.cit., p.1100

145 Senate Legal and Constitutional Legislation Committee, op.cit., p.11 [2:38]
had been *adequately palliated* and was experiencing “*no symptoms*” [emphasis added].

The fact that the patient had no desire to burden her family, was distressed by the idea of merely waiting to die and of no longer being able to live the kind of active lifestyle she had become accustomed to, were apparently sufficient grounds to solicit a termination on 1 March 1997. Philip Nitschke was wont to emphasise that a psychiatric assessment confirmed that there was no indication that the patient was incapable of making an informed end of life decision, or that she was in need of treatment for clinical depression.

This reassurance is, however, not entirely satisfactory for those of us who view PAS or AVE as distinctly *last resort* options that are undertaken in response to *unresolved and overwhelming* terminal pain. While it is conceded that even the most insightful of physicians ought not to presume to second-guess a patient’s *personal experience* of terminal distress, in Valerie’s case one could contend that there should have been a more rigorous eligibility assessment. More to the point, Territory authorities arguably had a duty to ensure that any patient who admitted to having *no symptoms* was disqualified from pursuing a last resort AVE or PAS option. If by chance an effectively palliated patient chose to deceive their physician by claiming that they were intolerably distressed, then short of compelling evidence to the contrary, their termination must of necessity have rested on their conscience alone. Obviously this is a legitimate concession as the *ROTTIA* was unable to comprehensively police this type of deceptive ambition—that is—without first imposing upon patients to demonstrate that which cannot always be definitively

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146 Nitschke & Stewart, op.cit., pp.146–147

147 ibid. See further Keown, op.cit., p.164

manifest by medical examinations and diagnostics. In light of that fact, ROTTIA advocates could not be condemned for favouring the ‘better judgment’ of intolerably afflicted rational terminal patients who, in the best of liberal tradition, were deemed the most appropriate assessors of their own quality of life.

Conclusion

In response to the claim that the Northern Territory parliamentary ROTTIA debate had been under-analysed from a political science perspective, this chapter has demonstrated that the Territory’s world first legislation was influenced by a variety of often competing liberal, democratic, utilitarian, and communitarian convictions. Despite assurances from Marshall Perron that the ROTTIA was capable of protecting the interests of all citizens, religious and secular critics alike expressed concern not only about the alleged moral impropriety of AVE and PAS, but also about the risk of a slippery slope debacle. While there was never any question that Territory authorities had a duty of care to ensure that the right to life was adequately protected, it was argued that these same trustee representative MPs also had a responsibility to accede to the overwhelmingly pro-choice electorate’s democratic desire for last resort choice in dying. Whilst it was argued that paternal restraint was only justified in circumstances where a patient’s life was at risk of an unwarranted or imposed termination, this provision evidently failed to convince those who maintained that the diminishment of the sanctity of life ethic would place vulnerable patients at risk of utility motivated euthanasia. Although an alleged lack of consultation and scaremongering on the part of the AMA had reportedly exacerbated public and specifically Indigenous unrest on the ROTTIA issue, it was argued that these largely avoidable minority grievances should not be permitted to stand in the way of democratic governance and the liberal self regarding rights of the pro-choice majority. This legislative reform agenda could not, however, hide the fact that the Administration had brought the ROTTIA’s crucial last resort
status into question after having failed to ensure that an optimal palliative care alternative was available for all patients. Whilst this palliative care shortfall clearly had to be rectified, it was duly conceded that even the best of treatment could not always resolve intolerable terminal distress.

This discussion’s endorsement of a right to die option did not, however, signify that the ROTTIA was without fault. Indeed, it was agreed that an unduly broad ‘terminal illness’ clause and an ambiguous ‘reasonably available’ care provision left the ROTTIA open to potentially unintended interpretations. The need for a more explicit definition of ‘terminal illness’ and an indication of precisely what alternate treatment options may be construed as ‘reasonably available’ was, thus, identified as crucial to the interests of vulnerable patients. It was later alleged by Keown that the ROTTIA’s emphasis upon ensuring rational and informed decision-making was undermined by the Act’s failure to specifically exclude patients with non-depression related mental ailments. In light of that fact, this chapter asserted that the Territory authorities had a duty of care to guarantee that potential AVE or PAS candidates were not only assessed for a range of reason distorting psychological maladies but were also exposed to counselling before authorisation was given to initiate a last resort termination.

The evidence at hand suggested that most patients who undertook a voluntary termination under the Act appeared justified as they were experiencing a variety of intolerably distressing symptoms. That claim notwithstanding, the last candidate identified only as ‘Valerie’ was characterised as a somewhat more questionable affair. The fact that this patient, by her own admission, was suffering no symptoms tended to negate the indispensable proviso that last resort AVE or PAS should be strictly limited to patients who are experiencing intolerable and unresolved terminal pain. It was, nevertheless,
conceded that without irrefutable evidence to the contrary, strictly vetted rational terminal patients who claim to have intolerable pain and suffering must ultimately be permitted to follow their own conscience in pursuing a good death. Unfortunately, the Federal Government took a largely unsympathetic view towards the Territory’s liberal choice in dying provisions, having moved to impose legislation designed to invalidate the *ROTTIA*. The political debate leading up to this contentious administrative intervention will, therefore, be the central focus of the next chapter.
9 THE COMMONWEALTH AND THE RIGHTS OF THE TERMINALLY ILL ACT

Introduction

The Commonwealth’s decision to invoke its legislative (disallowance) powers against the Northern Territory’s Rights of the Terminally Ill Act (ROTTIA) was a significant event in Australian politics as it gave rise to fundamental questions about the scope and application of political authority. It has previously been acknowledged, however, that existing literature has tended to focus upon singular aspects of the ROTTIA debate such as the role of religion in secular policy affairs or the legality of the Act itself. While these insightful contributions are clearly important, Australian and international scholars’ tendency to neglect a broad political theory analysis of the ROTTIA provides an opportunity to investigate how liberal–democratic principles, in particular, were brought to bear in order to justify the ensuing Euthanasia Laws Bill. Although it is reiterated that the ROTTIA was not without flaws, it will be argued that the Commonwealth’s decision to enforce its disallowance authority was a disproportionate response. It will be maintained, however, that criticism of this unduly heavy-handed intervention does not imply sanctioning of the

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ROTTIA’s shortcomings but rather, it is a protest against Federal MPs for failing to negotiate a compromise legislative solution. In order to provide a context for this debate, the discussion will firstly explore the unique relationship that the Northern Territory shares with the Commonwealth.

**The Federal Challenge to the ROTTIA**

The Northern Territory is positioned differently to that of the States in the Australian political landscape as its ability to enact legislation is subject to federal amendment or disallowance under the *Northern Territory Self Government Act* of 1978. Although this disallowance authority had never before been enforced, Liberal Prime Minister John Howard’s (LIB) invitation to formulate a Bill that would nullify the Northern Territory’s ROTTIA legislation was promptly acted upon by ultra-conservative colleague, Kevin Andrews (LIB). Despite the fact that Andrews’s subsequent *Euthanasia Laws Bill* appeared to be at odds with the Liberal Party’s traditional commitment to free enterprise and individual initiative, Andrews defended federal intervention on grounds that the ROTTIA had been passed by a legislature that represented “less than one per cent of the national population” and yet, the Territory Parliament’s unprecedented policy decision had the potential to adversely impact upon all Australians. The ROTTIA was very much a

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“national issue”, said Andrews, as people from all over the country had travelled to the Northern Territory seeking to take advantage of the Act’s world-first AVE and PAS provisions. In an attempt to countermand what the *Australian* newspaper depicted as this “radical social experiment”, the (Andrews) Bill stipulated that:

> the making of laws does not extend to the making of laws which permit or have the effect of permitting…the form of intentional killing of another called euthanasia (which includes mercy killing) or the assisting of a person to terminate his or her life.

It was further asserted that the Territory Administration’s decision to ignore the findings of international committees of inquiry, traditional medical ethics, religious objections, and alleged evidence of widespread active euthanasia abuse in the Netherlands (where regulated AVE was tolerated) was both pretentious and irresponsible. Andrews went on to recommend that the Federal Parliament had a duty of care to revoke the ROTTIA given that there could be no guarantee that the Territory Act would protect vulnerable patients from arbitrary or imposed terminations.

**The Territory Administration’s Response to Federal Intervention**

In response to the Commonwealth intervention the Northern Territory’s Minister for Health, Denis Burke, accused Kevin Andrews of having been “irresponsible” in stirring up...
misplaced antagonism and “fear” about the Territory’s “safe and voluntary” Act. While conceding that he was personally opposed to active euthanasia, Burke expressed the prevailing view of his parliamentary colleagues in asserting that Territorians should be free to dictate their own policy affairs. More explicit pleas for the Territory to be afforded administrative equality with the States were, nevertheless, overly optimistic under existing self government constraints. Given that a federal disallowance resolution could not be ruled out, Chief Minister Shane Stone delivered a remonstrance to the Federal Parliament (on 10 October 1996) outlining the Territory Assembly’s unanimous opposition to the Euthanasia Laws Bill. In particular, the document rejected any attempt on the part of the Commonwealth to “diminish” the Northern Territory’s self governing powers, and stressed that the proposed disallowance would be un-Constitutional had it been applied to any of the nation’s six States. The implication that “Territories have responsibilities not rights” was, said Stone, indicative of the Commonwealth’s “ultimate arrogance” in its mishandling of this ‘internal’ Territory matter. It was further alleged that if the Euthanasia Laws Bill

8 M Ceresa, “Minister Condemns Euthanasia Opponents”, *Australian*, 10 August 1996, p.8


10 Northern Territory Government, Hansard and Legislation, (Serial 174), p.8278


12 ibid., pp.9328–9329

13 A McGarry & M Ceresa, “Coalition Threat to Gag Death Bill Debate”, *Australian*, 1 November 1996, p.3
were allowed to proceed, it would permanently undermine the authority of local
governance by creating “uncertainty” in relation to all other Northern Territory laws.\textsuperscript{14}

**The Commonwealth Committee Room Controversy**

In spite of the fact that the Territory Administration maintained that it had acted in good
faith to fulfil its social contract or duty of care obligation to protect the right to life of all
citizens, the *Euthanasia Laws Bill* progressed to its second federal parliamentary reading
on 28 October 1996. Unlike the First Reading, which is essentially an opportunity to
introduce a Bill before the Parliament, the Second Reading allows for in-depth debate and
appraisal of a Bill’s provisions. With around 80 federal members wishing to speak on the
disallowance proposal, it was decided to reallocate all but 1.5 hours of Lower House
presentations to the Main Committee Room.\textsuperscript{15} In addition to claims that this arrangement
would avert a parliamentary bottleneck, it was anticipated that this more secluded
environment would help to ensure optimum scrutiny of the legislation by minimising
adversarial partisan point scoring. This purportedly pragmatic ruling failed to convince the
Australian Labor Party’s (ALP) Stephen Smith and Kelvin Thomson (ALP), however,
having maintained that the Bill’s “national importance” suggested that debate proceedings
should be undertaken in the House, as the Committee Room was intended to be used only
for the hearing of “the least controversial…pieces of legislation”.\textsuperscript{16} Related concerns about

\textsuperscript{14} Northern Territory Government, Hansard and Legislation, *The Remonstrance*, p.9328

See further Maddox, *God Under Howard*, p.54

\textsuperscript{16} Commonwealth of Australia, *House of Representatives (1996)*, p.6349 [31 October] & p.7332 [21 November]. As distinct from the Liberal Party the nation’s only other major Party, the ALP, favours strong rather minimal government aimed at preserving “equality, democracy, liberty and social cooperation”. A more comprehensive account of ALP objectives and ideological distinctives is available at – Australian Footnote continued on the next page.
the Committee Room’s limited public seating and lack of (radio) broadcast facilities failed to win over the parliamentary majority, however, as an appeal to conduct the entire debate in the House was rejected following a verbal vote.\footnote{17}

The Committee Room debate provided an indication of the tension that existed between those MPs who favoured optimal public accessibility to the parliamentary (\textit{Euthanasia Laws Bill}) process, and those who were motivated by arguably less democratic objectives.\footnote{18} In the former case, Independent member Peter Andren (IND) strove to communicate the intensity of public interest in the \textit{ROTTIA} intervention claiming to have been “besieged by letters” on this particular issue, whilst the Liberal Party’s Warren Entsch (LIB) indicated that he too had been “bombarded” with correspondence from concerned community groups.\footnote{19} In spite of that fact the leader of the House, Peter Reith (LIB), rejected calls for a House centred debate by reminding all concerned that the Government was “obliged to give priority in the chamber to the budget, budget-related matters and other Bills” which it had promised to implement at the last election.\footnote{20} Reith’s colleague Tony Abbott (LIB) was, nevertheless, dissatisfied with this explanation having pointed out that the \textit{Euthanasia Laws Bill} was “the most important Bill currently before Parliament”.\footnote{21} While Kevin

Andrews (LIB) claimed to have “considerable sympathy” with arguments in favour of a main chamber debate, Abbott’s petition was ultimately to no avail. Sceptics were, thus, left to speculate about whether disallowance advocates viewed a less exposed Committee Room environment as a soft option, fearing that their paternal views against popularly endorsed choice in dying might damage their re-election prospects. Those MPs who intended to support the *Euthanasia Laws Bill* on national interest grounds were particularly vulnerable, therefore, to criticism that they had failed to ensure optimal public disclosure of a nationally significant policy debate.

**The Issue of ‘States’ Rights and the Role of Government**

The issue of public accountability was also broached by Senator Kate Lundy (ALP) having challenged the *ROTTIA* disallowance on grounds that it would cause “damage to the social fabric of…society” by undermining “the democratic principles upon which Australia is based”. In so doing, Lundy tapped into a particularly sensitive issue for Territorians, as the Northern Territory’s arguably undemocratic self governance restrictions had contributed to the perception that Territory residents were unequal to their State counterparts. Kathryn Sullivan’s (LIB) attempt to convince the Andrews lobby that the

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22 ibid., p.7938 [5 December]


24 In fact, the disparity between the States and the Northern Territory is significant as the States are guaranteed 5 Federal House of Representatives seats with additional members dependent upon population size. The Northern Territory has just 2 representatives on the basis of population alone. In the Senate, each State is allocated 12 seats while the Northern Territory claims just 2 seats. As a result, a mere 4 out of 226 federal parliamentarians specifically represent the Territory electorate. See further Northern Territory Statehood Steering Committee, *Fact Sheet Two – How the Territory is not Equal to the States*, Northern Territory Government, June 2005, viewed 20 September 2007, <http://www.dcm.nt.gov.au/dcm/statehood/factsheets/200506factsheet2.shtml>.
intent at the time of implementing Territory self government was to “actively foster…equality, not some form of second-class statehood” was, nevertheless, destined to fall on deaf ears.\(^{25}\) Indeed, the unwillingness of disallowance advocates to apportion due consideration to the Territory Parliament’s detailed ROTTIA deliberations and careful assessment of public submissions led Senator Brenda Gibbs (ALP) to chide that the Commonwealth might just as well begin “dismantling” the Territory Government, as the Euthanasia Laws Bill would deny local constituents “control over their own destiny”\(^{26}\).

National Party representative Ian Sinclair’s (NP) proposal that an Australia-wide code on euthanasia was needed to ensure a more equitable outcome for Territorians failed to win House approval, however, on grounds that it was viewed as an attempt to salvage the ROTTIA.\(^{27}\) While this (82 to 45) defeat was characterised as yet another blow to Territory–State equality, the fact remained that even the most ardent critic could not deny that the Commonwealth was within its legal rights to discriminate against Territory residents by invoking its morally contentious disallowance authority.\(^{28}\)

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In an attempt to placate Territory anger over this looming disallowance action, Tony Abbott (LIB) stressed that the Commonwealth Government routinely passes legislation (in the field of industrial relations, for example) that has an “important” impact on both Territories and States. Federal support for the Euthanasia Laws Bill need not be interpreted as a prejudicial measure against Territory residents per say, said Abbott, but rather as a rebuttal of potentially hazardous active euthanasia and assisted suicide practices. Whilst Abbott’s colleague Peter Costello (LIB) was at least willing to acknowledge that this intervention could well be construed by some Territorians as “an intrusion into the rights of self government”, he too concluded that the ROTTIA raised “infinitely more important issues” than those relating to a narrow “division of powers” debate. This proved to be a bi-partisan contention, as Labor’s Eric Fitzgibbon stressed that the “choice between Territory rights” or “the right of every person to be given a chance to live” overrode the notion of ‘States’ rights. Those MPs who had pinned their hopes upon a sovereign rights thesis were, thus, encouraged by Senator Sandy MacDonald (NP) to instead focus upon the Northern Territory’s legislative responsibility to protect rather than erode the right to life. While there was no question that federal intervention may be warranted in order to ensure that adequate end of life safeguards were set in place, it was clearly “beyond the proper role of government”, said Senator Bruce Childs (ALP),

30 ibid., p.8021 [9 December]
31 ibid., p.7907 [5 December]
32 ibid., p.6903 [7 November]
to impose legislation that compelled people “to die slowly and painfully”. This line of reasoning had been anticipated by Kevin Andrews having previously asserted that the *Euthanasia Laws Bill* exemplified the values of good government because its chief aim was to protect society’s most vulnerable (i.e. sick, elderly, or disadvantaged) citizens from harm. The credibility of this intervention was, however, ultimately reliant upon a contentious assumption that the *ROTTIA* undermined the Government’s capacity to protect the right to life. Had that proven to be the case, then it was clear that the Commonwealth had an obligation to ensure that the Act satisfied minimum safety standards rather than opting to impose an excessively paternal agenda upon contrary-minded Territorians.

### The Commonwealth’s *ROTTIA* Critique

Independent MP Graeme Campbell (IND) spoke favourably about the *ROTTIA*, having contended that its inbuilt “safeguards” were “perfectly adequate” to protect the interests of all citizens. To some extent, it appeared that the Territory Act had satisfied this objective as an AVE or PAS agreement had to be freely entered into and if so desired, could be readily revoked at the patient’s behest. These purportedly stringent provisions made it

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37 The issue of State paternalism is further explored in Chapter Seven.


“nigh on impossible”, said Ian McLachlan (LIB), for a person’s interests to be violated by the imposition of non-voluntary or involuntary euthanasia.40 Despite the fact that other parliamentarians depicted the ROTTIA as a truly “enlightened” law and “a well crafted piece of legislation”, these perspectives were not shared by Martyn Evans (ALP) who counter-argued that the Act was “legally imperfect” for it had (allegedly) been devised with “too little consultation” and in an “unseemly haste”.41 A note of caution was also sounded by Senator Jacinta Collins (ALP) in relation to the ROTTIA’s unduly broad definition of a ‘terminal illness’ (i.e. an illness which “without the application of extraordinary measures or of treatment unacceptable to the patient, [will] result in the death of the patient”) noting that this clause could conceivably be applied to patients needing ongoing life-preserving treatment for diabetes or asthma.42 Although one could argue that preventative treatments such as insulin or ventolin could not be construed as extraordinary measures, it is fair to say that the ROTTIA would have benefited from the inclusion of terminology (such as that detailed in Oregon’s [1997] Death with Dignity Act) stipulating that a patient must be “diagnosed with a terminal illness that will lead to death within six months [emphasis added]”.43 Language similar to that of the Netherlands’ (2001) Termination of Life and Assisted-Suicide Act would have provided an additional safeguard in specifying that the patient is undergoing “unbearable suffering with no prospect of...
improvement [emphasis added]”. In accordance with these provisos, an AVE or PAS procedure could only have been legally undertaken in light of a credible patient–physician consensus that there was “no other reasonable solution” to their terminal suffering.44

It was of further concern for ROTTIA critics that Territory patients who were experiencing “unacceptable….pain, suffering and/or distress” could conceivably seek permission to end their life even though their request was motivated by issues unrelated to their terminal illness.45 Indeed, it was previously observed in Chapter Eight that an assessing psychiatrist was not required to establish if a patient was afflicted by any form of mitigating mental illness other than clinical depression which is, of course, a commonly recognised trigger for end of life requests.46 Whilst a ROTTIA advocate would likely have counter-claimed that a psychiatrist had to be “satisfied” that the patient was of “sound mind”, former physician Brendan Nelson (LIB) advised that after having practiced medicine for 13 years, the public would be “sadly misguided” to believe that even “10 psychiatrists” could be

44 Ministry of Foreign Affairs: Q & A Euthanasia, Netherlands Government, 2001, viewed 22 August 2007, <http://www.minbuza.nl/binaries/minbuza_care_pictures/pdf/c/c_56513.pdf>. By way of comparison, both the Netherlands and Oregon legislation share similar provisions to the ROTTIA. With the exception of the DWDA’s PVS only option, all three Act’s specify the need for a voluntary, rational, and informed end of life decision in response to an intolerable and incurable terminal ailment. The patient must be assessed by a second physician to confirm their diagnosis and be advised of alternate treatment options. As an added safeguard, penalties are imposed for terminations undertaken in response to threats or promise of reward. In order to protect the personal ethics of medical professionals, physicians retain the right to refuse to participate in a termination procedure. While the ROTTIA and DWDA extend choice in dying to patients 18 years and over, the Dutch have controversially made provision for minors 18 years and up to undertake a termination in consultation with their parents. See further Northern Territory Government, Rights of the Terminally Ill Act 1995, Government Printer of the Northern Territory, 1995, Termination of Life on Request and Assisted Suicide (Review Procedures) Act, Netherlands Government, 1 April 2002, <http://www.nvve.nl/assets/nvve/english/euthlawenglish.pdf>, Ministry of Health, Welfare and Sport, Dutch Policy on Voluntary Euthanasia, Netherlands Government, 2001, viewed 12 September 2003, <http://www.minvws.nl/english/themes.html?folder=441&page=13887> & Department of Human Services, Physician-Assisted Suicide: FAQ’s about Physician-Assisted Suicide.


certain that this was the case.\textsuperscript{47} This was, nevertheless, a contentious criticism as it implied that there could never be adequate surety that AVE or PAS patients were able to make a suitably informed self regarding (end of life) decision. The fact remained that despite the potential for psychiatric evaluation error or perhaps even bias, a collective agreement on a patient’s intolerable terminal suffering eligibility both at a professional and communal (patient–family) level would have tended to diminish the likelihood of an inappropriate or unwarranted termination. Although Brendan Nelson assumed otherwise, such an assurance would clearly have been bolstered by the mandating of multiple (such as 3) psychiatrists to come to a consensus before any ROTTIA termination approval was forthcoming.

An additional point of contention arose over the ROTTIA’s reference to “reasonably available” medical treatment, as Christopher Pyne (LIB) advised that the Northern Territory had “no medical oncologist, no palliative care specialist, a barely resourced domiciliary palliative care program”, and “virtually no radiotherapy services and not a single hospice”. It was “not surprising”, said Pyne, that the ROTTIA attracted popular local support, as supposedly ‘last resort’ AVE or PAS were probably viewed as the “only” means of finding adequate relief from severe terminal suffering.\textsuperscript{48} Indeed, a joint 1996 Queensland and Northern Territory University poll appeared to vindicate this claim, as only 34 per cent of Territory residents expressed confidence in the ability of Territory physicians to adequately relieve and control end of life pain.\textsuperscript{49} The Labor Party’s Leo McLeay speculated that the ROTTIA would tend to exacerbate this palliative care shortfall,

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\textsuperscript{48} Commonwealth of Australia, \textit{House of Representatives (1996)}, p.6752 [6 November]

\textsuperscript{49} “Euthanasia Poll shows Divided Attitudes in NT”, \textit{Age}, 26 February 1999, p.7
\end{footnotesize}
because legislators know that “it is harder to argue for a greater allocation of funds for programs for which there are cheaper alternatives”. This was a legitimate claim, as it would have been foolhardy to assume that utilitarian arguments in favour of limiting terminal patient resources (in order that funding might be used ‘more effectively’ elsewhere) would not be considered in a resource depleted environment, given the availability of an AVE or PAS option. It was apparent, therefore, that all Territorians had to have access to high quality palliative care facilities before the ROTTIA could be portrayed as a genuine last resort measure. While those federal MPs who were opposed to active euthanasia under any circumstances would not be placated by assurances of improved end of life safeguards, the passing of a federal amendment permitting Territorians to take up refusal of treatment legislation (i.e. allowing the appointment of a guardian to make medical decisions on the part of an incompetent patient) and a commitment to fund improved and expanded palliative care services were universally welcomed initiatives.

Mindful of the validity of warnings about legislative and resource shortcomings, a number of federal MPs sought to balance the Commonwealth parliamentary debate by focussing upon the fact that the ROTTIA provided transparency in end of life care and a level of protection for the terminally ill that they had not had in the past. While Senator Sue


51 Please refer to Chapter Five’s discussion of utilitarianism and economically motivated terminations.


Mackay (ALP) maintained that the Territory Act’s “strict guidelines” would “reduce the number of assisted deaths”, Australian Democrats’ Senator Cheryl Kernot (AD) warned that the *Euthanasia Laws Bill* would tend to counter-act this considerable benefit by forcing doctors and their patients to return to a culture of “illegal behaviour” and “a world of secret actions, lies and deceit”.54 It would be far better, said Kernot, if voluntary terminations could continue to be carried out within a “properly regulated and scrutinised” environment, rather than leaving AVE and PAS practices to be undertaken in a dangerously clandestine manner.55 More to the point, ‘slippery slope’ speculation about the ‘normalisation’ of non-voluntary and involuntary killings clearly had to be weighed-up against what the ROTTIA set out to rectify—not the least of which were the problems of unsupervised terminations and administrative indifference to individual (end of life) suffering.56

**The Sanctity of Life and Human Rights Debate**

The fact that *Euthanasia Laws Bill* advocates tended to link a dilution of the sanctity of life ethic with slippery slope eventualities led John Bradford (LIB) to conclude that the Government had a duty to assert itself as the principle “guardian” of “the right to live”.57

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The “right to die is not the same as the right to kill or be killed”, said Tony Abbott (LIB), as “States rights…can never be odds with human rights”.\footnote{ibid., p.7922 [5 December]} In spite of the fact that the \textit{Human Rights Declaration} and the \textit{International Covenant on Civil and Political Rights (ICCPR)} confirm that the right to life must be protected, Abbott’s perspective was not entirely convincing.\footnote{Office of the High Commissioner for Human Rights, \textit{Universal Declaration of Human Rights}, United Nations, Geneva, 1948, viewed 25 September 2003, <http://www.unhchr.ch/udhr/lang/eng.htm>.


\footnote{ibid., p.23. See Chapter Seven for additional discussion on the human rights issue.} While there can be no question that the liberal social contract obligates the State to adjudicate between competing interests in order to protect \textit{innocent} life and thereby help preserve civil society, if one interprets the \textit{ICCPR} stipulation that “No one shall be arbitrarily deprived of his life” as a \textit{discretionary clause}, then it is fair to conclude that rational individuals can voluntarily waive their right to exist because not \textit{all} cases of killing (consider, for example, active \textit{voluntary} euthanasia) can be credibly construed as an “arbitrary deprivation of life”.\footnote{\textit{ibid.}, p.23. See Chapter Seven for additional discussion on the human rights issue.} If anything, Australia’s ratification of the \textit{ICCPR}’s (Article 7) right of people \textit{not} to be subjected to “inhuman or degrading treatment” and its additional (Article 17) commitment to individual privacy, tend to favour claims in support of a \textit{last resort} AVE or PAS option.\footnote{\textit{ibid.}, p.23. See Chapter Seven for additional discussion on the human rights issue.}

\textbf{The Issue of Terminal Suffering}

The unwillingness of \textit{Euthanasia Laws Bill} exponents to acknowledge the legitimacy of patient initiated end of life choice led Michael Cobb (NP) to speak about a woman who had cancer of the face. This condition had not only left the patient’s teeth, mouth, and
portions of her skull exposed, but she was also unable to eat, exuded an odour of rotting flesh and was allegedly in “constant pain that was not relieved in any way by morphine”. The arguably needless perpetuation of this patient’s “marathon of torture” when an AVE or PAS procedure would have alleviated her distress was, said Cobb, simply “wrong”. In the Senate, Australian Greens Party leader Bob Brown (AG) referred to a similarly distressing case, explaining that one Annette Mallinson had been witness to the death of her father-in-law from prostate cancer and that despite the “best” of palliative care he had reportedly suffered “beyond what [she] thought the human body could bear”. Whilst morphine was routinely administered, Mallinson indicated that her father-in-law had deteriorated to the point where he could “no longer tell us where he hurt or what his needs were”. Any lingering assumptions that the medical profession had “all the answers” for pain control were similarly dispelled by Senator Jocelyn Newman (LIB) who had experienced, first-hand, periods where there had been quite literally “no relief” from her cancer related suffering. In his former role as a physician, Senator Bob Brown (AG) confirmed that he had personally witnessed a number of “undignified” and “unedifying” ends to (pain ravaged) lives that had previously been “wonderful and productive”. Indeed, these evocative testimonies could not be dismissed as mere partisan rhetoric as objective medical literature backed-up claims that the suffering of some terminal patients was intractable to


64 Commonwealth of Australia, Senate (1997), pp.1700–1701 [18 March]

65 ibid., p.1740 [18 March]

66 ibid., p.1700 [18 March]
all treatment.\(^{67}\) While the Andrews lobby had, up until this point, assumed the high moral ground in protecting vulnerable patients from harm, Senator Amanda Vanstone (LIB) compellingly counter-claimed that any society which prohibited intolerably distressed terminal patients from pursuing the beneficial option of last resort AVE or PAS could not claim to be “humane or compassionate”.\(^{68}\)

Although contrary to liberal–humanitarian sensibilities, anti-ROTTIA exponent Neil Andrew (LIB) attempted to rationalise the experience of unresolved terminal distress, having asserted that “life becomes more meaningful because of…suffering…and illness”.\(^{69}\) Andrew was certainly not alone in drawing this contentious conclusion, as Senator John Hogg (ALP) agreed that a decision to truncate the dying process might deny an important “experience” for both the patient and those around them.\(^{70}\) People would, therefore, do well to “face up to the good and the bad” in life, said Hogg.\(^{71}\) While it would be presumptive to dismiss these claims as entirely misguided, it is clear that the all important quality of life issue that had tended to distinguish MPs such as Amanda Vanstone from those who supported the ROTTIA’s disallowance, were often motivated by a traditional or religious sanctity of life assumption that it was always wrong to intentionally end a patient’s life.\(^{72}\)


\(^{71}\) ibid., p.1887 [19 March]

As such, Senator Richard Alston (LIB) confessed that it might be difficult for patients who lacked faith in an afterlife “to comprehend why you need to go through [such a] period of suffering”. Certainly those patients who held conflicting views on the merits of end of life distress had every right to question Alston and other trustee representative parliamentarians who appeared ready to perpetuate human misery on distinctly narrow ideological/religious grounds. Much to the chagrin of more liberal-minded MPs, Alston’s implicit spiritual assumptions were, nevertheless, an indication that arguably austere faith based beliefs would have a bearing on the outcome of the pending federal ROTTIA vote.

The Church and State Debate

Certainly no one should have been surprised that the Howard Government’s electoral commitment to a conservative moral values agenda would be reflected in its response to euthanasia reform. Indeed, it has previously been observed in this thesis that the Government’s influential Lyons Forum Christian faction (of which Prime Minister John Howard and Kevin Andrews were affiliated) was particularly sympathetic to the pro-life ideals of the conservative religious right. While Kevin Andrews’s assertion that it is “nonsense” to suggest that “religious arguments can’t be advanced” in the political arena has encouraged similar speculation, he nevertheless has maintained that he would be “loath” to approach any political debate on this basis alone. It appears that Andrews’s ‘secular’ rationale was grounded in something beyond what might be described as a strict


74 B Hurrell, “Social Values under Assault”, Advertiser, 5 May 2006, p.4

separation of Church and State conviction, having concluded that it was a futile undertaking to invoke religious arguments as “there’s always a religious counter-argument” in any policy debate.\(^76\) As a consequence of this desire to avoid divisive theological contentions or to be seen as being unduly swayed by religious convictions, Andrews reiterated that the primary motivation for the *Euthanasia Laws Bill* was to offset the potentially detrimental implications that legalised AVE and PAS would have on Australian society.\(^77\) Andrews’s more discreet parliamentary supporters proved equally reticent to express an outwardly religious viewpoint on the *ROTTIA* issue, as Marion Maddox has observed that unlike the Senate, “God scarcely entered the House of Representatives debate”.\(^78\) Indeed, Maddox points out that religious supporters of the Andrews Bill (and most particularly the Liberal–National Coalition’s Lyons Forum affiliates) tended to view more discreet ‘secular’ code as “tactically advantageous”, while only a handful of other Lower House MPs were prepared to express their underlying religious motivations.\(^79\) Once again, those who did so were inclined to emphasise the indispensability of the traditional sanctity of life principle and the notion that it was wrong to interfere with Divine sovereignty.\(^80\) Needless to say that *ROTTIA* advocates reacted unfavourably to these contentious moral claims, having rebuked Kevin Andrews and other

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\(^76\) M Maddox, *For God and Country – Religious Dynamics in Australian Federal Politics*, Department of the Parliamentary Library, Canberra, 2001, p.140

\(^77\) Maddox, *God Under Howard*, p.63

\(^78\) ibid., p.55. See, for example, Commonwealth of Australia, *Senate (1997)*, p.1892 & p.1907 [19 March]

\(^79\) Maddox, “For God and State’s Rights”, p.58

socially conservative parliamentarians for attempting to legislate against legitimate individual (end of life) choice.\textsuperscript{81}

In spite of concerted opposition to explicit or covert religiously motivated policy, there was still a measurable undercurrent of support for Senator Bernard Cooney’s (ALP) claim that theological interpretations could make a useful contribution to public policy.\textsuperscript{82} Senator Eric Abetz (LIB), in particular, took issue with a narrowly defined separation of Church and State interpretation that parliamentarians should isolate their religious beliefs while others who were motivated by equally contentious secular philosophies were free to impose their views on the \textit{ROTTIA} debate.\textsuperscript{83} Rather than remaining focused upon the perceived shortcomings of these ‘religiously motivated’ arguments, Mark Latham (ALP) sought to discredit Kevin Andrews (LIB), in particular, for setting out to enforce a policy which demonstrated more interest in “the rule of God than in the rule of law”.\textsuperscript{84} Senator Chris Schacht (ALP) was similarly occupied with the idea that Andrews and his Lyons Forum “fundamentalist” Christian affiliates were intent on dictating policy on “a whole range of social issues”.\textsuperscript{85} It was wholly inappropriate in a nation that was established upon a separation of Church and State principle, said Senator Sue Mackay (ALP), for these parliamentarians to harness “the force of law” in order to impose their private religious

\textsuperscript{81} ibid., p.5923 [28 October] & p.7351 [21 November]


\textsuperscript{83} ibid., p.1744 [18 March]

\textsuperscript{84} Commonwealth of Australia, \textit{House of Representatives (1996)}, p.7340 [21 November]

convictions upon others. Senator Kate Lundy (ALP) concurred that the Lyons Forum’s so-called “hidden moral agenda” and “extremely conservative” outlook was contrary to the “interests, values and beliefs” of the vast majority of Australians. In particular, Lundy maintained that the message of “intolerance, dispassion, arrogance and powerful moral bigotry” which purportedly underpinned the Lyons’ sponsored Andrews Bill deserved “no place in Australian law, public policy or society”. If these “moral crusaders” were to succeed in disallowing the ROTTIA, Lundy concluded that it would set a “dangerous precedent” for a myriad of other unwelcome (religion inspired) interventions.

The fact that the risks associated with secular philosophies (such as extreme forms of utilitarianism or liberalism) upon the individual or collective good were either ignored or too easily dismissed by Schacht, Mackay, and Lundy tended to expose these MPs as no more objective or impartial than their religious counterparts. While this is not to suggest that religious arguments in favour of disallowing (rather than amending) the ROTTIA were compelling, it bears reiteration that members of an ideologically diverse (liberal–democratic) parliament should not have assumed the authority to deny opposing (religious) camps the opportunity to contribute to what they believed was a more comprehensive policy good. Indeed, it is argued that religious advocates’ characteristic commitment to restrain extreme utilitarian or individualistic agendas is potentially invaluable. On this particular occasion, however, religiously motivated federal MPs would have been well advised to have deferred to the ‘God-given’ rational and self regarding moral agency of

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86 ibid., p.1868 [19 March]

87 ibid., p.2101 [20 March]

88 Please note that a more detailed analysis of the Church–State debate is available in Chapter Six.
The Debate over Public Consultation

It was a point of ongoing contention that despite the fact that as many as 78 per cent of Australians supported an AVE option, the majority of federal politicians (of religious and secular persuasions) appeared determined to defend an anti-euthanasia agenda. While it is recognised that popularly endorsed policy objectives should not be vindicated at the expense of justice and equality, this commitment to stifle euthanasia reform on ideological rather than strictly pragmatic grounds was clearly illiberal and undemocratic. This reticence to acknowledge the public will raised the ire of Warren Entsch (LIB) who reminded his fellow parliamentarians that they had a duty “to enact legislation that reflects the needs and the aspirations of the people”. This momentum was maintained in the Senate, with Bob Brown (AG) pointedly remarking that expressions of support for the Euthanasia Laws Bill “did not reflect the feeling of the people of Australia”. If the ROTTIA were to be disallowed it would not only send a message that Territorians were incapable of making an informed decision on the matter of end of life choice, but would also demonstrate that the Commonwealth was prepared to ignore the needless suffering of


90 Senate Legal and Constitutional Legislation Committee, op.cit., p.81 [7:5–6]


the very citizens that they were appointed to serve and protect. As such, the unpopular aspirations of a “vocal, well organised minority” of anti-ROTTIA activists should not, said Senator Bruce Childs (ALP), be permitted to undermine the interests of vulnerable patients or the Federal Parliament’s broader obligation to the principle of citizen driven (representative) democracy.

In response to calls for democratic accountability, *Euthanasia Laws Bill* advocates insisted that arguments in favour of constituent or poll-driven policy undermined parliamentary scrutiny to the potential detriment of the public interest. More particularly, the Parliament was depicted as having a responsibility to counter rather than affirm public misconceptions about the dying process as a typically excruciating and largely unmanageable process. In choosing to go beyond the role of a mere conduit of potentially misguided public sentiment, it was argued that MPs were within their rights to contest favourable AVE poll statistics because polling questions sometimes incited particular responses without providing a definitive indication of the understanding or intensity of a respondent’s commitment to their ‘preferred’ policy. A number of these MPs may have been mindful of the fact that citizen driven initiatives in the US States of Washington (1991) and California (1992) had failed to win popular ballot box endorsement even though initial pre-

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94 ibid., p.2083 [20 March]

95 ibid., p.2078 [20 March]. See further p.1891 [19 March]

96 ibid., p.1745 [18 March]

vote polls had indicated a contrary result. While a hard-hitting fear campaign (financed by pro-life lobbyists) appears to have been at the root of these voter turnarounds, it was conceivable that some constituents had a change-of-heart when they were made to feel personally accountable for the implementation of (end of life) legislative reform. These examples, notwithstanding, it is noteworthy that the majority of citizens in the State of Oregon confirmed their support for physician-assisted suicide legislation in public opinion polls and in two subsequent (1994 and 1997) referendums. While Australian MPs did not have the benefit of the latter November 1997 poll result, the 1994 referendum was sufficient to illustrate that poll support for legislative change could sometimes translate to a commitment to policy reform. As such, Australia’s own overwhelmingly pro-euthanasia poll data ought to have been viewed as a catalyst for further public consultation rather than as an opportunity for paternal parliamentarians to overrule the democratic process.

It was clear that no matter how contentious or divisive the political backlash, Andrews Bill supporters shared a consensus that the Commonwealth needed to demonstrate to the Territory Administration that it had the resolve to take a firm stance against the purportedly risk laden ROTTIA. For example, Prime Minister John Howard later remarked that he was well aware that polls were “heavily against” the Andrews intervention, but chose to “ignore” them in order to “vote for things that I believe in and not for things that might be

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popular”. In doing “what you believe to be right”, Howard’s parliamentary allies Brendan Nelson (LIB) and Ross Cameron (LIB) similarly concluded that it was necessary for politicians to exercise their discretionary (trustee representative) “duty” in opposing the flawed legislative agenda of the Northern Territory Parliament. While the opportunity for these and other Commonwealth MPs to assert a non-partisan conscience vote had last been offered to federal (Liberal) politicians when voting on the Sex Discrimination Bill in 1984, it had been some five years prior that the entire Parliament had exercised this option on the contentious issue of abortion funding. Confident in the knowledge that many of his Liberal–National Party colleagues maintained a distinctly conservative view on euthanasia reform, the Prime Minister explained that a self prescribed vote was also in order in relation to the Euthanasia Laws Bill because the issue of choice in dying went to “the very essence” of a person’s “religious…philosophical or moral view” of life.

The opportunity to cast a vote without the constraints of Party partisan obligations was endorsed by both Liberal and Labor MPs who maintained that it was impossible to represent another person’s conscience on the matters of AVE and PAS. Critics were quick to point out, however, that the Prime Minister’s claim that he held the “strongest


103 Maddox, *For God and Country*, p.118


possible reservations” about the ROTTIA, along with the Labor opposition leader Kim Beazley’s (ALP) equally emphatic opposition to active euthanasia, would prompt ambitious backbenchers to put their future career prospects first and vote in accordance with their respective leader’s prescribed preference.106 In light of this potential for a less than impartial parliamentary vote, Democrat Senators’ Cheryl Kernot and Andrew Murray expressed support for a more decisive referendum on the ROTTIA issue.107 This suggestion was, nevertheless, rejected on the contentious grounds that an informed public vote on the complex issues of legalised AVE and PAS would prove elusive.108 By way of example, Peter Nugent (LIB) maintained that “a lot of people confuse euthanasia with just turning-off life support systems”.109 Certainly it was in the interests of the anti-ROTTIA lobby to emphasise this ‘problem’ of public incompetence, with Andrew Southcott (LIB) equally inclined to ‘demonstrate’ this point by referring to polls which were overwhelmingly in favour of economically disastrous “high levels of tariff protection” and diplomatically damaging calls to “end Australia’s immigration programme”.110 Having said that, it was somewhat ironic that no such reservation was expressed by Southcott or other Government MPs about the public’s capacity to conscientiously appraise and ultimately endorse the Liberal–National Coalition in the previous federal election.


108 ibid., p.1884 [19 March]


110 ibid., p.7748 [4 December]
The Slippery Slope Debate

The Federal Parliament’s Euthanasia Laws Bill faction was not about to be swayed by arguments in support of citizen driven policy, for whilst Noel Hicks (NP) conceded that the ROTTIA was designed to minimise terminal suffering, he maintained that Nazi Germany’s notorious ‘euthanasia’ program had also started out with the “best” of intentions.\textsuperscript{111} While any comparison with the Nazis’ strictly utilitarian rather than compassion driven policy was rightly condemned as being “over the top….unnecessary and thoroughly offensive” by Senator Vicki Bourne (AD), the enormity of human rights violations that ensued under Hitler’s regime prompted a circumspect Bronwyn Bishop (LIB) to caution that this experience should at least “teach us a lesson”\textsuperscript{112}. To some MPs it appeared that the lessons of history had not been heeded, as Christopher Pyne (LIB) pointed out that in recent year’s scores of patients in the policy ‘progressive’ Netherlands had been let die or had their lives actively terminated \textit{without} their explicit consent.\textsuperscript{113} A Senate submission from John Keown affirmed that in “many” of these instances active euthanasia had been applied “even though alternatives were available, and the patient’s suffering was not unbearable”.\textsuperscript{114} Christopher Pyne (LIB) was, thus, moved to conclude that if the ROTTIA was permitted to remain in force, then similar abuses up to and including “involuntary euthanasia” might eventually follow in the Northern Territory.\textsuperscript{115} Indeed, one need not be a

\begin{itemize}
\item \textsuperscript{111} ibid., p.6741 [6 November]
\item \textsuperscript{112} ibid., p.7744 [4 December]. See further Commonwealth of Australia, Senate (1997), p.1883 [19 March]. Please be advised that Chapter Two of this thesis provides an overview of Nazi Germany’s ‘euthanasia’ policy with an emphasis upon the fascist regime’s distinctly utilitarian motivations.
\item \textsuperscript{113} Commonwealth of Australia, House of Representatives (1996), p.6752 [6 November]
\item \textsuperscript{114} Senate Legal and Constitutional Legislation Committee, op.cit., p.103 [8:48]
\item \textsuperscript{115} Commonwealth of Australia, House of Representatives (1996), p.6752 [6 November]
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hardline utilitarian to recognise the validity of Pyne’s argument that virtually any Administration could be tempted to view AVE and PAS as a way of minimising the financial and emotional burden of unproductive and/or costly (physically ill or disabled) patients.\textsuperscript{116}

Kevin Andrews (LIB) was keen to fuel concerns about the potential for more extensive active euthanasia procedures in the Northern Territory, having warned that the ROTTIA could not have come at a worse time as an ageing population, inflating medical costs, and a lack of hospital beds demanded greater taxation contributions from a community that could prove increasingly “reluctant” to shoulder this growing healthcare burden.\textsuperscript{117} The willingness of Territorians to subsidise care for the sick and dying could evaporate further, said Senator Brian Harradine (IND), given the option of more expedient active euthanasia or PAS alternatives.\textsuperscript{118} Indeed, Harradine envisaged that the legalisation of these practices would invariably place pressure upon burdensome patients “to make a deadly choice”.\textsuperscript{119} This “ultimate form of economic rationalism”, as Tony Abbott (LIB) aptly described it, implied that “everything has its price, even human life”.\textsuperscript{120} What was missing in this parliamentary (slippery slope) critique was an acknowledgment that most citizens are capable of distinguishing between a last resort patient-initiated termination, and that of an


\textsuperscript{117} Commonwealth of Australia, \textit{House of Representatives (1996)}, p.5907 [28 October]

\textsuperscript{118} Commonwealth of Australia, \textit{Senate (1997)}, p.1723. For a similar argument see p.1747 [18 March]

\textsuperscript{119} ibid., p.1724 [18 March]

uninvited end of life procedure that is enacted solely on the basis of third-party (utilitarian) preferences or assumptions.\textsuperscript{121} Placing their faith in the idea that citizens would continue to make this crucial distinction was, however, not something that the majority of federal parliamentarians were prepared to entertain.

Aboriginal Concerns

In spite of Territory Government assurances about the discretionary nature of citizen initiated AVE and PAS, critics such as the Committee on Social and Political Questions argued that legalised mercy killing would invariably impose “a subtle form of apartheid” upon vulnerable and marginalised citizens.\textsuperscript{122} While the sometime dependent and costly disabled and elderly were cited amongst the most obvious ‘at risk’ populations, it was clear that the Indigenous community had an equally legitimate stake in expressing misgivings about the \textit{ROTTIA}. Indeed, a series of fact finding public meetings held from June through October 1996 confirmed that “at least 90 per cent of Aboriginal [Indigenous] people in the Territory” were “opposed” to the Act.\textsuperscript{123} Whilst some of their concerns were touched on in the Northern Territory’s \textit{Select Committee Report on Euthanasia}, local parliamentarian Richard Setter insisted that a “lack of information” and misunderstandings in the minds of Indigenous people were “temporary” problems that could be rectified “in the course of time”.\textsuperscript{124} A number of Aboriginal constituents remained adamant, however, that the

\textsuperscript{121} Please note that a critique of utilitarian thought is provided in Chapter Five.


\textsuperscript{124} Northern Territory Government, Hansard and Legislation, (Serial 174), p.8283
ROTTIA was “not a suitable law for our people”. In particular, it was emphasised that the Territory euthanasia debate had focused largely upon Western moral arguments without adequate regard for the unique values and religious perspectives of the (45,000 strong) Aboriginal community. It is fair to say that this alleged oversight was far from atypical, as Marion Maddox has observed that the “Indigenous sacred” has traditionally been “repressed” or ignored by Australia’s dominant non-indigenous community. Needless to say that belated and arguably inadequate attempts to convince Indigenous people about the Act’s strictly limited aims failed to have “any significant impact” on customary views of sickness and death as sorcery related outcomes. The fact that Indigenous citizens were now increasingly reluctant to consult medical practitioners for fear of the so called sorcerer’s needle, led to the conclusion that the ROTTIA presented an ongoing threat to the health and wellbeing of Aboriginal residents. In light of these concerns, representatives of the Ramingining, Gapuwiyak, Galiwinku, and Milingimbi Indigenous communities petitioned the Northern Territory Parliament to disallow the Act, so that their people could continue to die in a ‘natural’ or “proper way”. A formal protest was also lodged in


127 Maddox, For God and Country, p.287

128 Mackinolty, op.cit., p.69

129 ibid., p.70

130 Northern Territory Government, Hansard and Legislation, Petition: Rights of the Terminally Ill Act, p.8191
Canberra stating that the *ROTTIA* not only defied “Customary Law”, but also undermined the capacity of government to ensure the safety of *all* citizens.\(^{131}\)

Federal Democrat Senator Meg Lees affirmed that Aboriginal reticence to endorse the *ROTTIA* as a safe and discriminating Act was demonstrative of an entrenched “lack of confidence” in white authorities who had historically manifested an attitude of “neglect” toward Indigenous citizens.\(^{132}\) The Senator’s claim was a valid one, as Aboriginals remained significantly disadvantaged in a variety of areas and not the least of which in the realm of healthcare, with statistics indicating that their life expectancy was on average 18 to 19 years less than non-Aboriginal citizens.\(^{133}\) Evidence of disproportionate life threatening and yet largely preventable illnesses such as kidney disease, cardiovascular disease, and diabetes contributed further to this inequitable state of affairs, with Indigenous people up to three times more likely than non-indigenous citizens to be hospitalised.\(^{134}\) While these chronic health issues remained largely unresolved, Senator Bruce Childs (ALP) complained that governments had effectively “ignored” the equally troubling problems of Indigenous suicide and the unacceptably high rates of deadly substance abuse.\(^{135}\) It was fitting, therefore, that there were expressions of sympathy in the Federal


\(^{133}\) National Health and Medical Research Council, *Nutrition in Aboriginal and Torres Strait Islander Peoples*, (NHMRC, Canberra, 2000) p.29

\(^{134}\) ibid., pp.27–28

Parliament for Aboriginals who had difficulty in accepting (Territory) Government assurances about their interests being protected in a post-ROTTIA climate.\textsuperscript{136}

By way of comparison, typically under-privileged (Indigenous) North American Indians have also suffered from poorer health outcomes and experienced “discrimination in the delivery of health services”.\textsuperscript{137} Despite that fact, this disparity in treatment has not translated into end of life (race-based) abuses in Oregon. In fact, most of Oregon’s PAS patients could not be characterised as belonging to ‘underprivileged’ minority groups as they tend to have a formal education, private health insurance, and ready access to hospice care.\textsuperscript{138} Raphael Cohen-Almagor has duly affirmed that “There is no evidence that the poor, uneducated…or socially isolated are disproportionately seeking or getting lethal prescriptions of drugs under the Oregon Death with Dignity Act.”\textsuperscript{139} While this evidence takes nothing away from Australian federal politicians’ sensitivity to the concerns of the local Indigenous community, it does suggest that Indigenous interests can be preserved without infringing upon the pro-choice ambitions of the non-Indigenous majority. Although a blanket prohibition on Indigenous terminations under the Commonwealth’s special race laws may have been necessary to resolve any lingering anxieties, it was clear

\textsuperscript{136} ibid., p.1872 [19 March]

\textsuperscript{137} Department of Health and Human Services, National Library of Medicine, American Indian Health, Department of Health and Human Services, USA, January 2006, viewed 13 October 2007, \texttt{<http://info.ihs.gov/Files/DisparitiesFacts-Jan2006.pdf>}.  


that any end of life safeguards needed to accommodate the option of monitored AVE or PAS for equally vulnerable non-Indigenous patients.\textsuperscript{140}

**The Issue of Individual Liberty**

More sceptical MPs saw fit to persist with claims that it would be a dereliction of administrative responsibility on the Commonwealth’s part if it failed to resist the ROTTIA’s implicit message that self determination preceded the wellbeing of marginalised citizens.\textsuperscript{141} In particular, Senator Kay Patterson (LIB) maintained that “Individual rights do not exist in a vacuum” and so the “right to self determination” had to be “balanced against the right of the sick and vulnerable to receive the protection of a just society”.\textsuperscript{142} This overtly ‘other regarding’ agenda was portrayed as a core consideration, as Brendan Nelson (LIB) agreed that the right to die was much less compelling than the right of fellow citizens to be free of “guilt” about their desire to go on living.\textsuperscript{143} The implicit assumption that non-voluntary and involuntary active euthanasia abuses were likely to arise in a post-reform environment was, nevertheless, open to dispute. In the absence of evidence to suggest that the ROTTIA had resulted in the non-consensual deaths of patients, it was necessary for the Andrews (LIB) lobby to instead focus on the claim that active euthanasia contravened the principle of autonomy because without life, liberty is also non-existent.\textsuperscript{144} The suggestion that an intolerably distressed terminal patient who underwent a last resort AVE or PAS

\textsuperscript{140} Williams & Darke, op.cit., p.664


\textsuperscript{142} Commonwealth of Australia, *Senate (1997)*, p.2091 [20 March]

\textsuperscript{143} Commonwealth of Australia, *House of Representatives (1996)*, p.7335 [21 November]

\textsuperscript{144} ibid., p.5907 [28 October]
procedure would suffer loss was not, however, persuasive. If the Andrews’ lobby was genuinely convinced about the need to preserve human autonomy, then not even passive euthanasia or the removal of life sustaining medical measures could be deemed as legitimate options, as the (pro-life) contention from liberty implies vitalism over compassion. According to this arguably illiberal ideal, the self regarding realm is not the sovereign domain of the rational individual but rather, it is subordinate to an externally enforced sanctity of life ethos.

Fortunately, a more pragmatic response on the issue of individual autonomy was forthcoming from Barry Jones (ALP) who was at least prepared to lay aside his sense of uneasiness about the Territory’s ROTTIA legislation in order to acknowledge euthanasia as a “central illustration of privacy”.145 There was, however, no doubt at all in Mark Latham’s (ALP) mind that the Territory Parliament had been right to interpret AVE as “very much a self regarding act”.146 Labor Senator Nick Bolkus (ALP) asserted that it was inappropriate, therefore, for the proponents of Kevin Andrews’s “insidious” Euthanasia Laws Bill to “disregard the rights and consciences” of rational citizens on autonomy grounds.147 The hypocrisy of Liberal Party politicians in supporting this illiberal Bill was also not lost on Senator Cheryl Kernot (AD) or Senator Kim Carr (ALP) with the latter deriving a sense of “ironic pleasure” in quoting John Stuart Mill’s ‘harm principle’ against the Government’s Andrews Bill supporters.148 In particular, it was compellingly argued that unless a patient’s

145 ibid., p.7327 [21 November]


end of life actions could be shown to damage the fundamental interests of others, a carefully vetted voluntary euthanasia or PAS procedure should remain exempt from paternalistic restraint.\textsuperscript{149}

While there was no question that morally aggrieved federal politicians had a right to express disagreement or even outrage about the self regarding end of life ambitions of Territorians, it was arguably more appropriate in a liberal–democratic society to permit rational terminal (adult) patients to undertake an AVE or PAS option than it was to oppress their individuality by imposing \textit{unwarranted} limitations. Those parliamentarians that favoured the latter option clearly failed to recognise that their willingness to impose paternal restraint (ostensibly in order to protect core liberal–democratic ideals such as autonomy, equality and justice) was arguably self defeating.\textsuperscript{150} In demonstrating that it is possible to oppose AVE on grounds that death nullifies liberty and that vulnerable (terminal or high dependency) patients may be viewed in a post-reform climate as lesser mortals (and thereby be dealt with in an unjust manner) the Andrews lobby really only accounted for one side of the policy equation. Whilst most of these Commonwealth MPs acknowledged that the State has an obligation to satisfy the fundamental (security) needs of its citizens, they refused to accept that liberty is valued because it is a means to an end. Similarly, one cannot claim to be an advocate of equality and justice—or of giving people what they deserve—without demonstrating a commitment to the universality of these


\textsuperscript{150} A concise overview of these core principles can be found in: G Maddox, \textit{Australian Democracy: In Theory and Practice – Third Edition}, Longman Cheshire, Melbourne, 1996, pp.522–533
principles in the lives of all citizens, including the intolerably pained terminally ill who express a credible desire to escape their unenviable existence.

Ratification of the Euthanasia Laws Bill

Despite spirited arguments in defence of the Territory’s (albeit imperfect) right to die legislation, on 9 December 1996 the Liberal–National Coalition dominated House of Representatives resolved to support Kevin Andrews Euthanasia Laws Bill with 88 members (comprising 64 Liberal-National, 2 Independent, and 22 Labor votes) in favour and just 35 (13 Liberal-National, 1 Independent, and 21 Labor votes) against.¹⁵¹ Having successfully passed the House of Representatives, Australian Greens Party Senator Bob Brown sought to place the Euthanasia Laws Bill in abeyance until a national referendum could be held on the ROTTIA’s disallowance. Much to Brown’s disappointment, 56 of 71 Senators rejected this proposal, along with an additional amendment that the Bill should be automatically repealed after two years in order to give federal parliamentarians the opportunity to reconsider their position.¹⁵² Having recognised that the tide of Chamber opinion was against the ROTTIA, Senator Bob Collins (ALP) drew attention to the plight of patients who had already satisfied the Act’s criteria, but had decided to postpone their deaths to “a time of their choosing”.¹⁵³ Collins encouraged his fellow Senators to endorse Bob Brown’s (AG) proposed transitional clause designed to permit patients who had already signed a Certificate of Request to still avail themselves of the Act’s end of life


¹⁵³ ibid., p.2295 [24 March]
provisions, in a post *Euthanasia Laws Bill* setting.\textsuperscript{154} Although it seemed unlikely that the Andrews lobby would be open to persuasion, Senator Brown (AG) appealed directly to his parliamentary colleagues to “have the decency and the integrity” to respect the wishes of these patients, whilst the leader of the Australian Democrats Senator Cheryl Kernot (AD) concurred that it would be simply wrong to deny these people due process by retrospectively imposing legislation.\textsuperscript{155}

One particular terminal patient—identified as Esther Wild—had been “quietly confident” that the Commonwealth Parliament would make an exception in her case, having delayed death in order to enjoy one final view of her garden at the end of the Territory’s wet season.\textsuperscript{156} In support of this postponement claim, Wild had drafted a letter to the Commonwealth Senate (dated 17 March 1997) detailing her problems of “debilitating oedema…relentless abdominal pain” and difficulties posed by her “colostomy care”.\textsuperscript{157} Whilst Wild acknowledged that medical specialists had done “a wonderful job” in keeping her symptoms “under control”, as a former nurse she was well aware that “a particularly difficult death” may still lie ahead of her.\textsuperscript{158} Unfortunately, some Senators took an unsympathetic stance toward ‘stranded’ patients such as Wild, insisting that prospective euthanasia candidates had been given ample opportunity to legally end their lives, as the

\textsuperscript{154} ibid., p.2297 & p.2305 [24 March]

\textsuperscript{155} ibid., pp.2298–2299 [24 March]


\textsuperscript{158} ibid.
Euthanasia Laws Bill had been on the Parliamentary agenda for at least six months.\textsuperscript{159} Suffice to say that this was the popular view, as Bob Brown (AG) and Bob Collins (ALP) transitional clause amendment was rejected in the wake of the Euthanasia Laws Bill (38 to 33) ascension on 24 March 1997. The Australian Greens leader duly lamented that he could “scarcely” believe the circumstances that he now found himself in.\textsuperscript{160} Indeed, Senator Brown (AG) was left to question how a handful of arguably insensitive politicians could have “so painlessly…disempower[ed] so many citizens”.\textsuperscript{161}

Watching on from the public gallery, physician and leading pro-euthanasia campaigner Philip Nitschke described the unfolding Senate process as an “unedifying spectacle” that was dominated by a select group of “callous bastards” who had no wish to honour the legitimate self regarding aspirations of intolerably distressed patients.\textsuperscript{162} With members of the media in tow, Nitschke implemented a symbolic public protest against the Andrews decision by burning copies of the Northern Territory Constitution and the ROTTIA on the steps of the Commonwealth Parliament.\textsuperscript{163} Throughout the Andrews Bill affair, this outspoken lobbyist had consistently maintained that it was not for ‘trustee representative’ politicians to “indulge their own petty concerns” on euthanasia reform but rather, the views of the majority of their constituents.\textsuperscript{164} Having labelled Euthanasia Laws Bill supporters as

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\textsuperscript{159} Commonwealth of Australia, Senate (1997), p.2300 [24 March]
\textsuperscript{160} ibid., pp.2308–2309 [24 March]
\textsuperscript{161} ibid., p.2294 [24 March]
\textsuperscript{162} Nitschke, op.cit., p.28
\textsuperscript{163} Nitschke & Stewart, op.cit., p.51
\textsuperscript{164} M Ceresa, “We cannot Fight MP’s – Stone”, The Australian, 11 December 1996, p.2
\end{flushleft}
“bastards and bitches”, Territory Chief Minister Shane Stone claimed that he and many of his constituents were also “seething with outrage” following this unpopular federal disallowance decision.\footnote{McGarry & Ceresa, op.cit., p.3. See further R Milliken, “Canberra Kills off the World’s First Right to Die Legislation”, \textit{Independent (London)}, 25 March 1997, p.14} While it must be said that these critics needed to acknowledge that a number of issues had to be addressed before the ROTTIA could have been described as sound, it was not surprising that the passing of the \textit{Euthanasia Laws Bill} managed to raise the ire of the broader Australian public, with talkback radio “deluged with calls” and major newspapers “flooded” with vitriolic comment against those “self righteous” and “fickle” politicians who had supported this heavy-handed federal intervention.\footnote{J Brough, “The Last Rights”, \textit{Sydney Morning Herald}, 29 March, 1997, p.22. See further “Letters to the Editor: Euthanasia the Death of Democracy”, \textit{Australian}, 26 March 1997, p.12} Robert Marr of the Coalition of Organisations for Voluntary Euthanasia predicted that these same politicians would ultimately “pay a price” at the ballot box for placing their “private beliefs” above “the wishes of the vast majority” of Australians.\footnote{Brough, loc.cit.} A High Court challenge against the Commonwealth’s ideologically biased and arguably disproportionate action was, nevertheless, out of the question as Chief Minister Stone reported that legal counsel had advised that any such appeal was unlikely to succeed.\footnote{M Ceresa & G Windsor, “Euthanasia Awaits Death Sentence”, \textit{Australian}, 25 March 1997, p.1}

Although Esther Wild petitioned the Governor-General Sir William Deane to delay signing the \textit{Euthanasia Laws Bill} into law until after Easter, Deane gave his assent on the Thursday immediately prior to the Easter weekend. With an AVE or PAS option now out of the question, Philip Nitschke set about palliating Wild’s pain with morphine. Unfortunately,
complications with the medication’s delivery ensured that the patient’s death did not come for several days, leaving Nitschke to retort that this “bizarre” and needlessly drawn out process was not “good medicine” but rather, an “obscenity”.\footnote{Nitschke, op.cit., p.29} While some would argue that this was too strong a term, there could be no dispute that the Euthanasia Laws Bill was tinged with irony. More to the point, this alleged policy victory for the right of citizens to live without fear of an unwarranted active euthanasia termination came at the cost of violating the liberal–democratic principles of self determination and popularly endorsed policy, along with the interests of a distinctly vulnerable patient such as Esther Wild.

**Conclusion**

This political science contribution to existing Euthanasia Laws Bill literature acknowledged that the liberal–democratic State had a duty of care to ensure that the ROTTIA adequately protected the interests of all citizens. The Federal Government’s decision to relegate this important debate to the Main Committee Room was, nevertheless, characterised as an attempt to minimise public exposure to the Parliament’s unduly heavy-handed disallowance agenda. Despite protests from the Territory Government that talk of disallowance was both subversive and discriminatory, it was conceded that the Commonwealth was within its legal rather than moral rights to overrule Territory legislation. Parliamentary critics rightly pointed out, however, that it was ultimately beyond the role of Government to compel people to die in an undignified and painful manner. Less convincing were those Federal and Territory MPs who argued that the Commonwealth intervention was unnecessary because the ROTTIA adequately protected patient interests. Indeed, the ROTTIA’s unduly broad terminal illness clause and inadequate
psychological assessment provisions clearly needed to be resolved if vulnerable individual’s interests were to be preserved. Additional criticism was also levelled at the Northern Territory’s meagre palliative care services and lack of medical guardian provisions which tended to undermine the ROTTIA’s crucial last resort status. The Commonwealth’s determination to disallow rather than amend this partially flawed Act on the basis of sanctity of life and/or slippery slope assumptions was, nevertheless, contested on grounds that rational individuals have a last resort right to flee inhumane and degrading terminal affliction.

While counter-arguments about ‘beneficial’ terminal suffering were often religiously motivated, Maddox observed that very few House of Representative disallowance advocates enunciated theological justifications. In the Senate, on the other hand, religious arguments in favour of the Territory Act’s immediate disallowance were comparatively prevalent. In seeking to nullify the influence of religious conservatives, a number of the Parliament’s ROTTIA sympathisers appealed to the separation of Church and State principle in rebuking Christian MPs (and particularly Lyons Forum affiliates) for attempting to deny the liberal right to freedom of choice. Although it was acknowledged that religious politicians needed to heed the democratically established (self regarding) wishes of Territory residents, it was maintained that faith based contributions should not be excluded from the euthanasia debate. Indeed, it was argued that the steadying influence of religious input in counteracting more extreme utilitarian or liberal (individualistic) agendas might ultimately prove indispensable in the pursuit of a more comprehensive (liberal–democratic) policy outcome.

It was observed that the decision of Federal MPs to ignore the popular will of Territorians in favour of their own (trustee representative) discretion was informed by a contentious
assumption about public ignorance and the risk of euthanasia abuses. In the latter case, it was conceded that patients’ rights might be violated if, for example, a cost saving utilitarian end of life policy were to prevail. This risk did not, however, imply that the ROTTIA was unworkable but rather that the Commonwealth had a duty of care to ensure that the Northern Territory authorities remained vigilant in protecting the (right to life) interests of all patients. While the marginalised local Indigenous community was particularly vocal in opposing the ROTTIA on cultural, historical, and healthcare grounds, it was maintained that these concerns did not reflect on the validity of popularly endorsed last resort AVE or PAS legislation. Indeed, it was emphasised that the desire to protect the (arguably reconcilliable) interests of Indigenous citizens had to be balanced with the right of terminal patients to exercise self regarding sovereignty over their own body and mind. Certainly it was contended that Federal politicians’ disproportionate disallowance response to the partially flawed ROTTIA was inconsistent with a commitment to exercise paternal restraint only in cases where patients were at genuine risk of an unwarranted harm. It was duly concluded that the core liberal–democratic principles of autonomy, equality, and justice would have been better served by ensuring that the rights of all citizens—which necessarily included AVE and PAS candidates—were adequately protected by more comprehensive legislative terminology. The alternate decision to disallow the ROTTIA was plainly unsatisfactory as Esther Wild’s prolonged dying highlighted the inequity of excessive State paternalism in the face of futile terminal suffering.
10 CONCLUSION

This thesis has argued that existing euthanasia literature is primarily written from a bioethics, medical, legal, or historical perspective with insufficient emphasis upon a political science analysis. This gap in the literature exists despite the fact that State sanctioned AVE has considerable implications for the politically implicated issues of the individual and collective good. Differing assumptions about the individual’s duty to self, the State and/or God have, subsequently, inspired disagreement over the legitimacy of end of life choice. Dissenting views were evident in the Ancient Greek and Roman worlds with Chapter Two revealing that the termination of a futile and/or intolerable existence was characterised by some as a prudent and dignified undertaking. Critics maintained, however, that individuals were obligated to submit their will to Divine sovereignty and to otherwise forbear action that would deprive the State of a contributing or valued member. While the influential Hippocratic medical fraternity was instrumental in eroding the cultural acceptability of euthanasia, Christianity and its elevation to the religion of Empire ultimately ensured that a ‘good death’ was forbidden on sanctity of life grounds. Sanctity of life assumptions were, nevertheless, called into question during the Enlightenment period as it was revealed that a growing number of religious sceptics and liberal clerics expressed support for beneficent choice in dying. This preference for pragmatism over faith based absolutism took on a renewed vigour during the 19th and 20th Centuries as liberal humanitarian arguments in favour of compassion and individual rights challenged traditional deontological assumptions about the impropriety of euthanasia.

Although it was conceded that the practice of euthanasia was ultimately exploited by Nazi physicians who were preoccupied with economic and ideological objectives, this disturbing human rights violation failed to discourage post-War authorities from responding to cases of genuinely beneficent euthanasia in a sympathetic manner. While
this trend was underscored by the implementation of progressive right to die legislation in Europe, an enduring prohibition against regulated AVE in the US and Australia resulted in arguably irresponsible end of life options being offered by unorthodox practitioners’ such as Jack Kevorkian and Philip Nitschke. Despite the fact that support for a more transparent legalised AVE alternative was controversial and not without risk, it was deemed regrettable that governments in the US and Australia remained reticent to endorse this much needed reform on the basis of contested sanctity of life and/or slippery slope (greater good) assumptions.

The third chapter of this thesis contended that there was a need for a re-evaluation of the traditional sanctity of (innocent) life principle given that around 5 per cent of treated terminal patients are unable to find adequate relief from their symptoms. While it was acknowledged that patients have a right to refuse extraordinary life sustaining medical measures (on quality of life grounds) and that the doctrine of double effect (via terminal sedation) allows some terminally ill individuals to succumb to an ‘unintended’ death, this was by no means an optimal arrangement. Indeed, it was argued that patient initiated last resort AVE provided a superior alternative to a covert or needlessly prolonged dying process. It was, nevertheless, conceded that the concerns raised by anti-euthanasia critics about the risks that State sanctioned euthanasia may pose for vulnerable patients could not be ignored. The tendency of reform advocates to underestimate or downplay slippery slope contentions was, subsequently, critiqued in light of evidence of unauthorised non-voluntary euthanasia procedures in the Netherlands. While it was acknowledged that the number of non-voluntary deaths has been on the decline, Dutch authorities’ willingness to allow a convicted physician to go unpunished for assisting a healthy individual to end their life on grounds of debilitating depression demonstrated that the risks associated with ‘legislative creep’ or an overly accommodating and subjective termination criteria must be guarded
against via governmental regulation. The fact that this particular termination was driven by a prevailing individual rights ethos led to the conclusion that the underlying liberal ideal of patient autonomy needed to be further scrutinised.

Chapter Four’s exploration of John Stuart Mill’s highly influential *On Liberty* thesis revealed that his contested harm and interest doctrines were susceptible to manipulation and/or questionable end of life interpretations. This perspective was informed by a conviction that *On Liberty’s* tolerance for unorthodox views, penchant for social experiment, and opposition to ethical absolutism potentially undermined crucial moral considerations. Certainly it was suggested that liberal Western society’s ‘other regarding conscience’ has already been weakened by a readiness to tolerate questionable and arguably illiberal behaviour such as ‘non-essential’ abortions. Mill’s contrastingly optimistic view of inter-dependent human beings as largely rational and altruistic was not, therefore, deemed a sufficient deterrent to ensure that vulnerable patients are protected from exploitation in a post-AVE reform environment. Indeed, it was argued that excessive self interest and an aversion to traditional moral restraints could result in the rationalisation of other regarding euthanasia abuses. Unfortunately, the alternative option of Immanuel Kant’s inflexible ‘perfect duty’ view on the sanctity of life ran counter to an indispensable sovereign (end of life) rights agenda. With Kantian thought discounted, it was concluded that Mill’s well intentioned yet flawed individual rights ethos would benefit from a companion ethic that could act to restrain excessive self interest and the rationalisation of potentially unwarranted euthanasia deaths.

Despite the fact that many in the bioethics fraternity favour a distinctly utilitarian end of life ethic, it was argued in Chapter Five that this cost–benefit approach is unacceptable because it places the interests of dependent and marginalised patients at the mercy of a
subjectively devised greater good. While it was conceded that utilitarians are mindful of competing interests and can conceive of the greater good in terms of moral ends, it was evident that virtually any moral value (including the sanctity of life principle) is potentially expendable in the pursuit of a utility maximising ideal. As such, a responsive communitarian ethic was depicted as a morally superior and more compassionate policy platform as it aims to provide an equitable balance between the rights of the individual and that of the collective interest. While the thesis acknowledged that communitarianism’s emphasis upon mutual obligations has a paternalistic undercurrent, a commitment to communal accountability reflected the reality that certain mutually beneficial (other regarding) ideals need to be upheld. It was, therefore, an anomaly that communitarian analysis on the issue of euthanasia is extremely limited given that this philosophy’s endorsement of communally conscious individual liberty, equality, dignity, and compassion are arguably conducive to last resort AVE advocacy.

Chapter Six’s analysis of the Church’s predominantly adversarial yet communally conscious role in the euthanasia debate revealed that reform advocates have often attempted to invoke the separation of Church and State principle in order to neutralise their religious opponents. It was counter-argued, however, that the US and Australian Founding Fathers never intended to ensure freedom from religion but rather, had anticipated that the Church would play a defining role in the nurturing of a moral citizenry. Criticism was, nevertheless, levelled at the George W. Bush Administration for its unduly close relationship with the pro-life religious right and the subsequent Executive–Congressional initiative aimed at preserving PVS patient Terri Schiavo’s life. While the right of politicians to be influenced by religious lobbyists and personal faith based convictions was defended, it was clearly inappropriate for these liberal–democratic representatives to have ignored Schiavo’s express wish to die, overwhelming public sentiment in support of a
passive euthanasia solution and a Judicial ruling ordering that the patient’s feeding tube be removed. In Australia, the Federal Government’s move to disallow the Northern Territory’s democratically formulated ROTTIA was also characterised as having a religious undercurrent as critics accused Bill supporters of seeking to impose a narrow and unrepresentative spiritual agenda upon Territory residents. Despite that fact, calls to quarantine religious (parliamentary) opposition to the ROTTIA were rejected on grounds that any such initiative would undermine the liberal–democratic principles of freedom of conscience and social diversity. The efforts of Church groups to deny intolerably afflicted terminal patients a last resort AVE option were characterised as equally inappropriate, as it was argued that rational individuals have a right to assert their self regarding sovereignty in end of life affairs. While it was conceded that some in the Church feel that they are morally obligated to counsel against active euthanasia, it was maintained that these religious lobbyists should be content to act as an adjunct to the secular authority of the State by playing the part of a ‘moral auditor’ in ensuring that other regarding non-voluntary and involuntary abuses remained prohibited in a post-AVE environment.

In fulfilling its obligation to act as a protective instrument of the people, it was conceded that there may be occasions when the State’s trustee political representatives will be required to enforce their discretion in relation to potentially ill-conceived policy initiatives. Although this endorsement of discretionary authority gave rise to legitimate concerns about representatives imposing a privately devised (anti-AVE) version of the good, there were instances where the Government needed to exert its authority (as exemplified by Australia’s Suicide and Material Offences Act) to discourage depressed, irrational, and impulsive individuals from ending their lives without just cause. In contrast to legitimate anti-suicide policy initiatives, it was observed that the US Attorney General John Ashcroft’s non-consultative Oregon intervention unduly disregarded Federal Government
and Judicial precedent in the administration of prescription only drugs in State monitored end of life procedures. It was argued that Ashcroft’s ideologically motivated characterisation of Federal drugs in citizen endorsed PAS procedures (as contrary to legitimate medical purposes) could not be justified on either moral or illegal diversion grounds. Nor could the Attorney General provide a sufficient guarantee that the interests of Oregon patients would not be placed at a significant disadvantage under this amended prescribing regime. Fortunately, Ashcroft’s invasive agenda was ultimately refuted by the Judiciary as a violation of constitutional and democratic principles. Judicial criticism was also levelled against George W. Bush and his Congressional supporters in their efforts to overrule Terri Schiavo’s Court affirmed wish not to be sustained in a futile vegetative state, and the guardian authority of Michael Schiavo to order the removal of extraordinary medical assistance. Indeed, it was argued that in both cases Federal representatives had succumbed to unduly paternalistic, illiberal and undemocratic ideological (pro-life) pressures.

The issue of State intervention was further investigated in Chapter Eight with the under-analysed Northern Territory parliamentary debate on the Rights of the Terminally Ill Act reigniting sanctity of life versus quality of life and human rights contentions. While it was maintained that the ROTTIA was designed to ensure dignity in dying, parliamentary critics insisted that the Government was incapable of limiting the scope and practice of active euthanasia terminations. This view was shared by the medical profession, Church groups, and Indigenous communities who favoured the (arguably inadequate) Natural Death Act over and above the allegedly unethical and risk laden practices of AVE and PAS. It was, nevertheless, pointed out that opposition to the ROTTIA was at least partially influenced by a lack of education and consultation regarding the Act’s limited provisions. Concerns raised about the threat of wholesale arbitrary or imposed terminations were duly depicted
as excessive and largely unsubstantiated speculation that should not be permitted to deny
the legitimate self regarding (AVE) rights of intolerably afflicted terminal patients. This
was not to suggest that the ROTTIA was without fault, as the Territory Administration
clearly had an unresolved duty of care to firstly ensure that all patients had access to a
palliative care alternative. It was further conceded that the ROTTIA included ambiguous
and unduly broad terminology (regarding, for example, terminal status and access to
alternate treatment options) that invited a variety of interpretations about patient eligibility.
The Act’s failure to require an assessment of patients for mental ailments other than
depression led to the suggestion that more comprehensive terminology and provisions were
needful if unwarranted terminations were to be avoided. The fact that one terminal patient
was able to end her life without any symptoms gave rise to the contention that the Territory
authorities had failed in their duty of care in this particular instance, as genuinely last
resort AVE and PAS provisions should have been strictly limited to those patients whose
terminal pain was intolerable and unmanageable.

In spite of the ROTTIA’s shortcomings, it was argued in Chapter Nine that the
Commonwealth’s disallowance initiative was an unduly heavy-handed tactic. Although
there was never any question that Commonwealth representatives were obliged to ensure
that Territory patient interests were adequately protected, it was clearly beyond the role of
Government to disallow legislation that aimed to reduce needless terminal pain and
indignity. Indeed, it was reiterated that the Territory Act should instead have been partially
redrafted in order to incorporate more comprehensive legislative language, such as that
found in Oregon’s Death with Dignity Act and the Netherlands’ Termination of Life and
Assisted Suicide Act. The readiness of Federal MPs to ignore the popular will of
Territorians on AVE and PAS reform was reflected in their decision to transfer the
Euthanasia Laws Bill debate from the parliamentary chamber to the less accessible Main
Committee Room. A review of *Hansard* revealed that Committee Room arguments about the *ROTTIA* violating human rights principles were convincingly refuted on grounds that the right to life was not in question, only the opportunity to undertake AVE or PAS as a last resort alternative to unmanageable and burdensome terminal affliction.

The suggestion by some Andrews’ lobby supporters that patients should try to draw benefit from suffering inspired protests from a number of Senators who singled out the Government’s religiously affiliated Lyons Forum for specific criticism. Although it was conceded during the course of this discussion that the self regarding rights of Territorians should *not* have been denied on purely ideological grounds, neither was it acceptable to exclude religious voices from contributing to a liberal–democratic policy debate. It was contended, therefore, that a balance needed to be struck between the individual and collective interest, or self and other regarding rights, so that *all* patients could be reasonably assured that they would be dealt with in an equitable and compassionate manner. This ideal was plainly contravened after the Commonwealth’s self prescribed advocates of vulnerable patient rights abandoned Esther Wild and other terminal patients to needlessly linger in a debilitating and futile terminal state. While it was reiterated that politicians had an obligation to weigh-up the individual and collective (slippery slope) risks associated with the legalisation of AVE, this need not have resulted in the disallowance of much needed legislation aimed at providing intolerably distressed terminal patients with the *option* of a beneficent *last resort* ‘good death’.

This thesis has argued that while there are potential risks associated with the legalisation of AVE, it is reasonable to expect that trustee politicians will remain responsive to the public interest by implementing measures designed to avoid an unacceptable slippery slope digression. Toward that end, this discussion’s exploration of a range of liberal, democratic,
utilitarian, and communitarian arguments revealed a number of flaws in reform advocacy, with US and Australian case study analyses reinforcing the notion that any right to die option needs to be strictly regulated by the State to offset active euthanasia abuses. In maintaining that it is possible to adequately protect and uphold the end of life interests of patients via stringent legislation and strict monitoring, this thesis has challenged policy makers and citizens alike to reflect on their responsibility to uphold the collective good without unduly contravening intolerably distressed terminal patients’ legitimate right to last resort euthanasia. It has also contributed to existing euthanasia literature with its primarily medical, bioethics, theological, and/or legal emphasis, by focusing upon the comparatively neglected issues of political theory and practice. Indeed, this thesis has endeavoured to not only pull together key arguments in relation to AVE reform but also to point out how the euthanasia debate can provide valuable political insights in relation to the rights of the individual and the responsibility of the State to uphold the collective good.
GLOSSARY

Euthanasia

Euthanasia is derived from the Greek word *eu-thanatos* which signifies a swift and gentle ‘good death’.¹

**Active Voluntary Euthanasia (AVE)**

AVE involves the termination of a consenting (rational) patient’s life in order to bring an end to an intolerably pained existence.²

**Non-Voluntary Active Euthanasia (NVAE)**

NVAE involves the termination of an incompetent patient’s life on grounds that it is in their perceived best interests to do so.³

**Involuntary Active Euthanasia (IAE)**

The compassion motivated killing of a patient without their express permission or in contravention of their explicit plea to live.⁴

¹ RK Barnhart & S Steinmetz (eds.), *Chambers Dictionary of Etymology*, Chambers, New York, 2000, p.347


Passive Euthanasia (PE)

PE involves the omission or suspension of treatment (such as life support technology, surgery, intravenous infusions and/or drugs) in the knowledge that it is likely to hasten the demise of a futile life.\(^5\) The medical profession typically characterises PE as an expression of effective palliative care.\(^6\)

Physician Assisted Suicide (PAS)

A physician consciously provides a requesting patient with the means to self-administer their own death.\(^7\)

Suicide

An independent undertaking that specifically aims to bring about the death of the participant.\(^8\)

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\(^7\) Somerville, op.cit., p.106

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