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Euthanasia and Physician Assisted Suicide

Introduction

The aims of this paper are to examine in brief the current legislation or proposed legislation in Australia surrounding voluntary assisted dying (VAD), to explore a biblical perspective on end-of-life care and to highlight some of the concerns about euthanasia and physician assisted suicide (PAS) based upon the current literature. This paper is intended to equip churches to engage in robust discussions about assisted dying and to challenge all Christians to examine how they care for people at the end-of-life. It is authorised by the Baptist Association's Public Engagement Group. For definitions of terms used in this paper, please see the Glossary of Terms at the end of the document.

*Please note, this paper was updated on 27 September 2021.

Previous Statement

In 1995, the NSW and ACT Baptist Association produced the following statement:

In light of the growing debate on the availability of euthanasia:

- We deplore the ignorance and lack of resources which doom many to avoidable suffering. We call upon the State and Federal Governments to ensure that the best Palliative care is available to all who need it.
- We acknowledge and grieve for the distress and pain of those with severe physical and mental disability and illness and of those who care for them. We resolve to support them with love, compassion and practical care. We acknowledge that this will often mean sacrifice of both time and life style.
- We call on all Christians to be aware of the needs of those least able to protect themselves - i.e. the very young and the very old, those with physical and mental disabilities, the ill, the confused and the lonely and resolve to be ready to act as advocates for them whenever necessary.
- We call on all Christians to be informed and involved in the community debate about euthanasia and we resolve at all times to seek the mind of Christ and the guidance of the Spirit in our personal and corporate views.
- We believe that human life is a gift from God and it is His alone to give and take away. We resolve to inform governments that attempts to alter the law to allow legal euthanasia and physician assisted suicide should be resisted in the light of the above.
- We deplore the action of the Northern Territory legislature in introducing legal euthanasia.

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This statement is still current, though the final point is not presently relevant.

Background

Euthanasia describes the process of intentionally terminating a person's life to reduce their pain and suffering.[1] Physician assisted suicide (PAS) is the voluntary termination of one's own life with the direct or indirect assistance of a physician.[2] In general, euthanasia means that the physician administers the life-ending drug while in PAS patients administer it to themselves. Some people prefer to use the term Voluntary Assisted Dying (VAD) instead of PAS because it recognises the person was dying of a terminal disease before accessing life-ending drugs. Euthanasia does not mean giving pain relief that may shorten life if the primary intention is pain relief, nor does it mean respecting a patient's right to refuse treatment or withdrawing or withholding life-sustaining treatment that has become futile.

Euthanasia and PAS have been made legal in some countries around the world. Euthanasia is legal in Spain, Belgium, Luxembourg, the Netherlands, Canada and Colombia.[3] It will become legal in New Zealand in November 2021.[4] After a previous ban on assisted suicide, Germany's parliament has introduced legislation to allow for assisted suicide for terminally ill patients.[5] PAS is legal in some states of the United States, in the Australian states of Victoria, Western Australia, and at a future date in Tasmania and South Australia.[6] [7] PAS was legal in the Northern Territory (NT) for two years (from 1995) when the law was voided after the federal government banned the NT and the ACT from legalising assisted suicide.[8]

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[1] Australia Human Rights Commission. 2016. "Euthanasia, human rights and the law." Accessed on 27 March 2019: https://www.humanrights.gov.au/our-work/age-discrimination/publications/euthanasia-human-rights-and-law
[2] MedicineNet. "Medical definition of physician assisted suicide." Accessed on 27 March 2019: https://www.medicinenet.com/script/main/art.asp?articlekey=32841
[3] BBC News. 18 March 2021. "Spain passes law allowing euthanasia." Accessed on 02 August 2021: https://www.bbc.com/news/world-europe-56446631
[4] Jha, P. BBC News. 30 October 2020. "New Zealand Euthanasia: Assisted dying to become legal for terminally ill people." Accessed on 02 August 2021: https://www.bbc.com/news/world-asia-54728717
[5] Reuters. 29 January 2021. "German lawmakers propose new law on assisted suicide." Accessed on 02 August 2021: https://www.reuters.com/article/us-germany-politics-euthanasia-idUSKBN29Y1KS
[6] Queensland University of Technology. "Euthanasia and assisted dying." Accessed on 02 August 2021: https://end-of-life.qut.edu.au/euthanasia
[7] SBS World News. 15 August 2018. "Euthanasia: where does the rest of the world stand?" https://www.sbs.com.au/news/euthanasia-where-does-the-rest-of-the-world-stand
[8] O'Toole, K. and E. Smith. 28 Jun 2018. "ACT, NT may regain control of euthanasia laws – 21 years after landmark legislation was voided." https://www.abc.net.au/news/2018-06-27/nt-may-regain-control-of-its-euthanasia-law-act/9915478

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In late 2017, Victoria became the first state in Australia to legalise voluntary assisted dying (VAD).[9] The process involves three steps with two independent medical assessments. The patient must be 18 years of age or older and must be "suffering in a way that 'cannot be relieved in a manner that the person deems tolerable.'"[10] Upon passage of the bill, Victorian Premier Daniel Andrews stated, "I'm proud today that we have put compassion right at the centre of our parliamentary and political process."[11]

In 2017, an assisted dying bill failed to pass by one vote in the NSW Upper House.[12] In July 2021, Mr. Alex Greenwich, MP, introduced a draft VAD Bill in NSW for public consultation with the aim to table it formally later in the year. Details of the VAD Act in Victoria and Greenwich's VAD Bill in NSW will be discussed in more detail further on in the paper.

Considering the current public and political discussions on assisted dying, it is helpful for Christians to explore a biblical perspective on caring for people at the end-of-life and look at some of the concerns around assisted dying based upon Scripture and based upon reviews of the legislation in place around the world.

A Biblical Perspective

Three themes from Scripture are explored below to guide conversations regarding euthanasia and PAS and reflect on the type of support Christians can and should provide those who are dying. These themes are: a) Inherent value of people, b) God's concern for suffering and Jesus' ministry of healing, and c) Characteristics of a Christian community.

a. Inherent value of people

What is it about people that gives them worth? Is it the ability to be productive? Is it the fact that they have interests that drive them to do work and make things? Is it that they contribute in some way to family, community, work and society as a whole? Scripture says that the inherent value of a person comes from the fact that they were created in God's image (Gen. 1:26-27). Humans have been created by God and for God and He knew them before they were born. Psalm 139: 13-14 says, "For you created my inmost being; you knit me together in my mother's womb. I praise you because I am fearfully and wonderfully made." In Luke 12:6-7, when talking about

[9] Edwards, J. 2017 Nov 29. "Euthanasia: Victoria becomes the first state to legalise voluntary assisted dying." https://www.abc.net.au/news/2017-11-29/euthanasia-passes-parliament-in-victoria/9205472
[10] Ibid
[11] Ibid
[12] Australian Associated Press. 2017 Nov 17. "Assisted dying bill fails to pass by one vote in New South Wales Upper House." https://www.theguardian.com/australia-news/2017/nov/17/assisted-dying-bill-fails-to-pass-by-one-vote-in-new-south-wales-upper-house

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who to fear, Jesus says, “Are not five sparrows sold for two pennies? Yet not one of them is forgotten by God. Indeed the very hairs on your head are all numbered. Don’t be afraid; you are worth more than many sparrows.” There is no caveat placed on this worth. Humans are not worth more than many sparrows because they work hard or because they contribute to community life; they are worth more than many sparrows because God has made it so.

Most non-Christian views of interpersonal ethics would similarly argue that, “Human dignity rests not on a person’s interests, but on the value of the person whose interests they are; and the value of the person is infinite” (p248).[13] While life should not be extended at all costs, people do not lose their value simply because they lose bodily function, or have diminished mental capacity, or because they require extensive care and attention from others. They do not lose their value because they feel as though they are no longer contributing and are a burden to others. Christians affirm the inherent worth and value of people regardless of what legislation or culture says.

Scripture affirms the value of all people, especially the poor, the sick, the marginalised, and the weak. In Matthew 8, Jesus heals the man with leprosy, in Matthew 9 he acknowledges the woman who had been bleeding for twelve years, in Matthew 20 he has compassion on two blind men, in Luke 7 he lets a sinful woman anoint his feet, in John 4 he approaches a Samaritan woman with whom others would have no contact, and so on. As followers of Jesus, we are called to model our lives and communities upon his example and thus affirm the value in all people.

b. God’s concern for suffering and Jesus’ ministry of healing

God has concern for, and he comforts those who are suffering. 2 Corinthians 1:3-4 says, “Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves have received from God.” Psalm 34:18 says, “The Lord is close to the broken-hearted and saves those who are crushed in spirit.” God also entered into human suffering through Jesus, to take on the pain and suffering of the world and to ultimately defeat death. Hebrews 2: 9 says, “But we see Jesus, who was made a little lower than the angels, now crowned with glory and honour because he suffered death, so that by the grace of God he might taste death for everyone.”

Jesus, through his ministry of healing, brought comfort to those who were suffering. Sometimes this was physical comfort; sometimes it was mental or emotional comfort.

[13] Sulmasy, D.P. et al. 2016. “Non-faith-based arguments against physician-assisted suicide and euthanasia.” The Linacre Quarterly 83 (3) 2016; 246-257.

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In Luke 6:6-10 we see Jesus heal a man with a shrivelled hand. In John 11, Jesus weeps over the death of his friend Lazarus and then raises him from the dead. Jesus offers emotional comfort when he says in Matthew 11:28, “Come to me, all you who are weary and burdened and I will give you rest.” In Acts 10:38 highlights the spiritual comfort Jesus gives saying, “how God anointed Jesus of Nazareth with the Holy Spirit and power, and how he went around doing good and healing all who were under the power of the devil, because God was with him.”

Followers of Jesus are sometimes asked to provide physical comfort and emotional and spiritual care to those who are sick or dying. Christians should support policies and actions that “express solidarity with people whose vulnerability has been exposed.”[14]

c. Characteristics of a Christian Community

Christians living in community are called to love and support one another in ways that shine a light in the darkness of death and suffering. There are characteristics of a Christian community that do not change despite the changing landscape around them. In community, Christians are meant to “bear one another’s burdens in love” (Gal. 6:2). They are called to provide for one another’s physical needs. In Acts 2:45 the fellowship of believers sold their possessions to give to those in need.

God requires his followers to act justly. Micah 6:8 says, “He has showed you, O man, what is good. And what does the Lord require of you? To act justly and to love mercy and to walk humbly with your God.” In Psalm 82:3-4 kings and judges are called to, “Defend the cause of the weak and fatherless; maintain the rights of the poor and oppressed. Rescue the weak and needy; deliver them from the hand of the wicked.” In Proverbs 31: 8-9, God is represented as the defender of those who cannot speak for themselves: “Speak up for those who cannot speak for themselves, for the rights of all who are destitute. Speak up and judge fairly; defend the rights of the poor and needy.” These examples and commands in Scripture provide guidance on how to approach death and dying and people who are suffering. Christians are to help bear others’ burdens, provide for their physical needs, act justly towards them and care for those who are most vulnerable.

Christians can also approach death without fear because they know the promises that Christ gave regarding an eternal life with him. 1 Corinthians 15:55-57 says, “’Where O death is your victory? Where O death is your sting? The sting of death is sin, and the power of sin is the law. But thanks be to God! He gives us the victory through our Lord Jesus Christ.” John 11: 25-26 says, “Jesus said to her ‘I am the resurrection and

[14] Sloane, A. (2019). Interview with Dr. Andrew Sloane. Morling College. 09 April 2019.

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the life. The one who believes in me will live, even though they die; and whoever lives by believing in me will never die. Do you believe this?'" John 14:1-2 says, "Do not let your hearts be troubled. You believe in God; believe also in me. My Father's house has many rooms; if that were not so, would I have told you that I am going there to prepare a place for you?" These promises can provide hope when talking about death and can help to bring the fears people keep in secret about dying out in the open so that they can be discussed. Churches can be communities that comfort those who are dying by providing space and resources to have conversations where people can explore the answers to the spiritual questions that they have.

Euthanasia and PAS do not seem to fit well as tools to care for dying people in communities where:

- all people are recognised as having inherent value
- people who are dying are comforted physically, emotionally, and spiritually in the model of Jesus' ministry
- those who are weak and in need are defended and provided for

Euthanasia and PAS: A brief look at the literature

There are a number of concerns raised about euthanasia and PAS in the literature. Several of these are discussed below: a) Euthanasia and PAS, are they compassionate responses to unavoidable suffering?, b) Problems with the legislation and the potential of abuse, c) Slippery slope, and d) Change in the nature and direction of medicine. Prior to examining these further though, it is helpful to take a brief look at some of the reasons why people support PAS.[15]

Proponents of PAS have concern for the alleviation of suffering for people at the end-of-life. Some people have witnessed the difficult deaths of their loved ones or have concerns for their own deaths and the pain that may be involved. Unfortunately, pain has not been properly managed in all deaths and this has led to intense suffering towards the end-of-life. In the absence of certainty around the alleviation of pain and suffering through palliative care, it is seen as an act of compassion to allow people to end their own lives through euthanasia. This argument is addressed in section a) *Euthanasia and PAS, are they compassionate responses to unavoidable suffering?*

Another significant reason why people support assisted dying is because they believe that it should be up to the individual to decide when and how death occurs. Proponents of assisted dying argue that it is possible to build enough safeguards into

[15] Best, M. (2018). Presentation for Anglican Deaconess Ministries School of Theology, Culture and Public Engagement . "Euthanasia".

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the law to protect vulnerable people and still allow the individual the right to choose assisted dying. However, a close look at how PAS laws play out shows that full autonomy in decision making is difficult to achieve. This point and concerns about abuses of the law are addressed in section b) *Problems with the legislation and potential of abuse*.

People also support PAS because they feel that doctors are already performing euthanasia, so it is best to make it legal rather than it be performed underground and in an unregulated manner. This argument has its basis in utilitarianism, that "moral rules should be designed to produce the greatest happiness of the greatest number of people" (para. 6, under Euthanasia Happens Anyway).[16] It is helpful to look at the effects of assisted dying on society when examining this argument. These effects are touched upon briefly in sections b and c below.

a. Euthanasia and PAS, are they compassionate responses to unavoidable suffering?

Supporters of euthanasia and PAS say that it is a compassionate response to suffering at the end-of-life and that since the pain cannot be managed, it is more compassionate to let a person end his or her life than to continue in incurable pain. Before exploring this further, it is important to note the difference between pain and suffering. Pain is defined as an "unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage" (p. 61).[17] Suffering on the other hand is more all-encompassing. Two people can experience the same level of physical pain but their level of suffering can be different. One effort to define suffering says,

> …suffering is defined as 'an all-encompassing, dynamic, individual phenomenon characterized by the experience of alienation, helplessness, hopelessness and meaninglessness in the sufferer which is difficult for them to articulate. It is multidimensional and usually incorporates an undesirable, negative quality' (para. 340).[18]

[16] BBC. Pro-euthanasia arguments. Available at: http://www.bbc.co.uk/ethics/euthanasia/infavour/infavour_1.shtml. Accessed on 06 June 2019.
[17] International Association for the Study of Pain (IASP). IASP terminology, December 2017. Available at: http://www.iasp-pain.org/Education/Contest.aspx?ItemNumber1698# as referenced in Brennan, F. et al. 2019. "Access to pain management as a human right." AMJPH 2019; 109: 61-61.
[18] Best, M. et al. 2015. "Conceptual analysis of suffering in cancer: a systematic review." Psycho-Oncology. 2015. DOI: 10.1002/pon.3795.

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In the majority of cases at the end-of-life, physical pain can be effectively managed with pain medication used in palliative care.[19] Suffering on the other hand requires a more comprehensive approach, incorporating resources that address physical, emotional, and spiritual needs as well as the opportunity to remain a part of community and family if desired.[2021]

Pain is rarely a reason given for requesting euthanasia and PAS.[2223242526] The most common reasons given for requesting euthanasia and PAS have more to do with loss of autonomy, being a burden to others, existential concerns and a fear of future suffering, not a present experience of unbearable pain.[27] There are therefore questions that arise around what defines unavoidable or intolerable suffering in euthanasia and PAS legislation since suffering is not just about physical pain. It is the difficulty in defining this term that contributes to future loosening of the legislation.

Reviews of euthanasia highlight concerns that in some jurisdictions patients who request it do not legally have to be reviewed by psychologists to ensure that they are not suffering from untreated mental illness that may be influencing a desire for euthanasia.[2829] In the U.S. states of Oregon and Washington, less than 4% of patients who had PAS had a psychiatric consultation.[30] In some instances, patients had shopped around for a doctor that would perform euthanasia or write a prescription for a lethal drug if the first doctor did not agree that the patient was a candidate for the intervention.[31] This does not necessarily mean that a great number of patients with depression are being allowed access to euthanasia and PAS but rather that there is not an adequate review of the psychological state of patients upon their request of a hastened death.[32] There are medical and other interventions that

[19] Hendin, H. and K. Foley. 2008. "Physician-assisted suicide in Oregon: A medical perspective." Michigan Law Review. 106 (8).
[20] Best (n15)
[21] Wood Mak, Y.Y. and Elwyn, G. 2005. "Voices of the terminally ill: uncovering the meaning of desire for euthanasia." Palliative Medicine: 2005 (19:343-350).
[22] Emanuel, E. 2017. "Euthanasia and physician-assisted suicide: focus on the data." MJA 206 (8).
[23] Sulmasy (n10)
[24] Wood Mak and Elwyn (n18)
[25] Hendin and Foley (n16)
[26] Hudson et al. 2006. "Desire for hastened death in patients with advanced disease and the evidence base of clinical guidelines: a systematic review." Palliative Medicine 2006; 20:693-701.
[27] Ibid 19-23
[28] Emanuel (n19)
[29] Hendin and Foley (n16)
[30] Emanuel (n19)
[31] Hendin and Foley (n16)
[32] Ganzini, L. et al. 2008. "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross-sectional survey." BMJ 2008:337:a1682.

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could have assisted the patient with his or her mental suffering, potentially eliminating a desire for euthanasia.

At the end-of-life there can also be great fluctuation in people's desire for euthanasia and often when the options of palliative care are discussed or some fears about death are alleviated, they desire to have more time, not less with loved ones.[33][34][35] Wood Mak and Elwyn (2005) found that,

> …the will to live in the terminally ill is known to fluctuate during the course of illness, legalising euthanasia is at best, contentious and at worst, unreliable (p. 343) [and that] the desire for euthanasia cannot be interpreted at face value. Its meaning is not confined to the reality of physical disintegration or suffering from the effects of cancer but includes fears and existential concerns with desire for connectedness, care and respect, understood within the context of the patients' whole lived experience (p. 348).[36]

While on the surface, giving people the ability to end the intense physical pain they are experiencing when facing imminent death seems compassionate, there are questions that arise as this plays out. Why isn't pain the number one reason given for requesting euthanasia? If pain can be managed through palliative care in most instances, why is there a need for euthanasia? If the suffering that a person is experiencing can be lessened by addressing emotional, mental, physical, and spiritual concerns, why aren't more resources devoted to holistic care at the end-of-life? Isn't it risky to allow someone to end his or her life when the person may have changed his or her mind in a week or two as often happens towards the end of life?

b. Problems with the legislation and the potential of abuse

In a perfect world, maybe euthanasia and PAS could be carried out only in the strictest of circumstances when individuals are of sound mind, have no untreated mental health issues and no pressure from friends or family members. However, a brief review of the literature reveals that there are issues with even the tightest legislation and there is great difficulty in protecting patients from outside pressures on their decisions at the end-of-life.

As mentioned above, the words used in various forms of euthanasia law such as "unbearable suffering" or "suffering that cannot be relieved in a manner that the

[33] Hudson et al. (n23)
[34] Wood Mak and Elywn (n18)
[35] Chochinov, H.M. et al. 1999. "Will to live in the terminally ill." The Lancet; 354:816-819.
[36] Wood Mak Elwyn (n18, p. 343,348)

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person considers tolerable" can be open to interpretation. What constitutes unbearable?[37] Even in Oregon's strict legislation around PAS, the word "incurable" can be extended to cases where a patient could seek treatment and live longer but chooses against it.[38] Despite the best intention, the difficulty in putting parameters around "suffering" opens the laws to interpretation and to loosening the law as the practice of euthanasia becomes more widespread and accepted in society. Suffering is subjective and no third person can say that one person's suffering is more or less than another's. It is this subjectivity that makes it difficult for the legislation to remain untouched once in place.

In a 2008 review of PAS in Oregon, published in the Michigan Law Review, Hendin and Foley state that, "Implementation of Oregon's Death with Dignity Act may have had unintended harmful consequences" (p1614).[39] They state that, even with a number of safeguards in place (presenting patients with the option of palliative care, ensuring patients are competent, limiting the procedure to patients who are terminally ill, ensuring the voluntariness of the request, etc.)…the evidence strongly suggests that these safeguards are circumvented in ways that are harmful to patients (p1614).[40]

The law enables physicians to assist in dying without inquiring into the psychological, social and existential concerns of the patient. The physician is not required to meet the family of the patient and witness family interactions to ensure the patient is not being coerced. Physicians are expected to inform patients of alternatives to euthanasia without being required to know about the alternatives or consult someone who knows.[41] In a review of Belgian euthanasia laws, Cohen-Almagor (2009) also found that physicians granting euthanasia do not possess "the necessary palliative know-how and experience" (p438).[42]

Hendin and Foley also express concern over the involvement of an assisted dying advocacy group in Oregon, Compassion in Dying, with patients who are terminally ill. Compassion in Dying has stated that by 2008 the group had been involved in 75% of

[37] Dierickx, S. et al. 2016. "Euthanasia in Belgium: trends in reported cases between 2003 and 2013." CMAJ, Nov 1 2016, 188 (16).
[38] Stahle, F. 2018. "Oregon health authority reveals hidden problems with the Oregon Assisted Suicide Model." Accessed at: http://img.scoop.co.nz/media/pdfs/1812/Stahle__Hidden_Problems_with_Oregon_Model.pdf
[39] Hendin and Foley (n16)
[40] Ibid (p1614)
[41] Ibid
[42] Cohen-Almagor, R. 2009. "Belgian euthanasia law: a critical analysis." J Med Ethics 2009; 35: 436-439.

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all cases of PAS since implementation of the law.[43] The group forms relationships with patients and coaches them through the process as well as helps patients find a doctor who is willing to assist in PAS. There are no mechanisms in place to rectify disagreements between physicians, and patients can continue to look for a physician who will assist in dying when another one turns them down for not meeting the criteria.[44]

When it comes to the involvement of families, it seems almost impossible to protect vulnerable patients from feeling as though they should seek PAS to not be a burden to their families. In Oregon, physicians are required to suggest that patients tell their families that they want assisted suicide but in order to protect patient confidentiality, physicians are not required to meet with family members.[45] It is difficult to know when family coercion is happening but when families are not involved in the process, it "opens the family up to the devastating grief and guilt that [we] see in survivors of suicide" (p1626).[46] How can doctors fully know the conversations and pressures put on vulnerable people at the end-of-life? How can they be assured that a patient hasn't felt burdened to quicken his or her death to make it "easier" for the family? How can they know that a family would not have stepped in to mend relationships and help ease the suffering of a patient at the end-of-life if given the opportunity to know that their loved one was considering euthanasia? It is impossible to fully safeguard family conversations and interactions.

A report on euthanasia in the Netherlands highlights some of the abuses of euthanasia law. In the 1990's, a committee was appointed to investigate how euthanasia was carried out in the Netherlands. A report was produced called the Remmelink Report in which Dutch physicians were interviewed around their euthanasia practices. The details of the physicians were kept anonymous. Euthanasia had been permitted in the Netherlands since 1984 if practiced with "due care" although it was not made legal until 2001.[47] Pieces of the Remmelink Report are discussed and reviewed in a 2006 Fulbright Report. The Remmelink Report found that at the time of the report 3% of all deaths were reported as euthanasia or PAS, 1,040 patients were euthanised without having given explicit consent, and 8,100 patients died from an intentional overdose of morphine or another painkiller (not a

[43] David, J. 2007. "Physician-Assisted suicide v Palliative Care: A tale of two cities as cited in Hendin, H. and Foley, K. 2008. "Physician-assisted suicide in Oregon: A medical perspective." Michigan Law Review. 106 (8).
[44] Hendin and Foley (n16)
[45] Ibid
[46] Ibid (p1626)
[47] Deliens, L. and G. van de Wal. 2003. "The euthanasia law in Belgium and the Netherlands." The Lancet. Volume 362, Issue 9391, p1239-1240.

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side effect of the painkiller).[48] Another Dutch study referenced in the Fulbright report found that 2/3 of Dutch doctors had certified that a patient died of natural causes when the patient had died of euthanasia and that at least half of Dutch physicians took the initiative by suggesting euthanasia to patients. The Fulbright report states, "When euthanasia was first accepted in the Netherlands, it was supposed to be a rare event. Over time doctors broadened or loosened the guidelines or completely ignored them. The law did not punish those who broke the law" (p109).[49] The report further states that "Protective guidelines offer very little shelter against abuses" and that "it is clear for those who want to see: euthanasia and assisted suicide are not only bad medicine but even worse public policy" (p126).[50]

Cohen-Almagor (2009) also found that doctors were carrying out euthanasia without proper consent.[51] In the Flemish region of Belgium, more than 3 in 100 deaths were the result of lethal injection without patient consent.[52] Hendin and Foley (2008) note that in Oregon, it is impossible to know how many PAS cases are not reported because to do so would mean granting immunity to physicians as was done in the Netherlands.[53] One can imagine that in Australia, this will also be the case; in order to get the complete picture of PAS, physicians will have to be granted immunity and interviewed or surveyed anonymously.

c. Slippery Slope

In addition to what has been discussed above regarding abuses that have occurred within euthanasia law, euthanasia laws in some countries have been changed from their original intent to allow for euthanasia of infants and adolescents as well as euthanasia for diseases that are not terminal. An article in the Guardian about euthanasia in the Netherlands raised some significant concerns with where that country's euthanasia legislation and practice has landed nearly 20 years since euthanasia became legal. Journalist and author, Christopher de Bellaigue, states,

> In the past few years a small but influential group of academics and jurists have raised the alarm over what is generally referred to, a little archly, as the 'slippery slope' – the idea that a measure introduced to provide relief to late-stage cancer patients has expanded to include people who might otherwise live for many

[48] Caplan, A.L. et al. 2006. "The Fulbright Brainstorms on Bioethics: Bioethics Frontiers and New Challenges." Principia
[49] Ibid (p109)
[50] Ibid (p126)
[51] Cohen-Almago (n39)
[52] Ibid
[53] Hendin and Foley (n16)

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> years, from sufferers of diseases such as muscular dystrophy to sexagenarians with dementia and even mentally ill young people. (para. 7)[54]

In the Netherlands, euthanasia or PAS was made legal in 2001. In 2004, children under the age of 12 were given the right to access euthanasia. Groningen University Hospital also developed the Groningen Protocol for decisions around actively ending the life of a newborn who has no chance of survival, low expectation of survival following the end of intensive treatment or who would have had a poor quality of life associated with sustained suffering.[5556] In 2007 the range of conditions that determined eligibility were relaxed and now people are able to indicate in advanced care directives that they would like to be euthanised if they develop dementia.[57] In 2020, doctors in the Netherlands were given permission to euthanise children aged one through 12, who have a terminal illness.[58] The Guardian reports, "As the world's pioneer, the Netherlands has also discovered that although legalising euthanasia might resolve one ethical conundrum, it opens a can of others – most importantly, where the limits of the practice should be drawn" (para. 7).[59]

In Belgium, euthanasia or PAS became legal in 2002 for competent adults and emancipated minors. In 2014 it became legal for children.[60] The number of recorded euthanasia cases in Belgium increased every year from 235 in 2003 to 1807 in 2013. The rate of euthanasia among those 80 or older, those in a nursing home and those with a disease other than cancer and those not expected to die in the near future increased significantly.[61] Dierickx et al (2016) state that the increase is likely due to an increase in requests and less reluctance to grant requests, not an increase on pressure on the vulnerable. They state, "The gradual increase in acceptance of euthanasia within society is a likely reason for these changes" (pE412).[62]

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[54] de Bellaigue, C. 2019. "Death on demand: has euthanasia gone too far?" 18 Jan 2019. The Guardian. Accessed at: https://www.theguardian.com/news/2019/jan/18/death-on-demand-has-euthanasia-gone-too-far-netherlands-assisted-dying. Para. 7
[55] Sulmasy et al. (n10)
[56] Verhagen E. and Sauer P.J.J. 2005. "The Groningen Protocol – Euthanasia in Severely Ill Newborns." N Engl J Med 352; 10.
[57] de Bellaigue, C. (n49)
[58] Boffey, D. 15 October 2020. "Dutch Government backs euthanasia for under 12's." Accessed on 16 August 2021 at https://www.theguardian.com/world/2020/oct/14/dutch-government-backs-euthanasia-for-under-12s?CMP=share_btn_link.
[59] Ibid (para. 7)
[60] Sulmasy et al. (n10)
[61] Dierickx, S. et al. (n34)
[62] Ibid (pE412)

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Professor Theo Boer, who once supported euthanasia and was a member for nine years of a regional review committee in the Netherlands, expressed his concern with the direction of euthanasia in the Netherlands. It is worth quoting below at length,

> For no apparent reason, beginning in 2007, the numbers of assisted dying cases started going up by 15 percent each year. In 2014 the number of cases stood at 5,306 nearly three times the 2002 figure.
>
> With overall mortality numbers remaining level, this means that today one in 25 deaths in the Netherlands is the consequence of assisted dying. On top of these voluntary deaths there are about 300 nonvoluntary deaths (where the patient is not judged competent) annually. These are cases of illegal killing, extracted from anonymous surveys among physicians, and therefore almost impossible to prosecute. There are also a number of palliative sedation cases 'the estimate is 17,000 cases yearly, or 12 percent of all deaths' some of which may involve shortening the life of a patient considerably. Furthermore, contrary to claims made by many, the Dutch law did not bring down the number of suicides; instead suicides went up by 35 percent over the past six years.
>
> A shift has also taken place in the type of patients who seek assisted dying. Whereas in the first years the vast majority of patients, about 95 percent, were patients with a terminal disease who had their lives ended days or weeks before a natural death was expected, an increasing number of patients now seek assisted dying because of dementia, psychiatric illnesses, and accumulated age-related complaints.
>
> Terminal cancer now accounts for fewer than 75 percent of the cases. Many of the remaining 25 percent could have lived for months, years, or even decades.
>
> In some reported cases, the suffering largely consists of being old, lonely, or bereaved. For a considerable number of Dutch citizens, euthanasia is fast becoming the preferred, if not the only acceptable, mode of dying for cancer patients. Although the law treats assisted dying as an exception, public opinion is beginning to interpret it as a right, with a corresponding duty for doctors to become involved in these deaths. A law now in draft form would oblige doctors

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> who refuse to administer euthanasia to refer their patients to a willing colleague (para. 11-15).[63]

The Guardian reports that more and more doctors in the Netherlands are unwilling to perform euthanasia as they have concerns about euthanising patients that could have lived for decades.[64]

In the first half of 2018, cases of euthanasia in the Netherlands were down 9% compared to 2017.[65] Some Dutch doctors also report that if they had known earlier about what treatments were available through palliative care, they would have behaved differently towards their patients.[66]

Is it possible to avoid the slippery slope? Some would say "yes" and cite Oregon as an example.

And yet even in Oregon, the overall effect of the legislation on society needs to be addressed. PAS in Oregon became legal in 1997. According to the U.S. Centres for Disease Control and Prevention, Oregon's suicide rate increased by 49% between 1999 and 2010 (the national rate was 28%).[67] Oregon's health department says the state's suicide rate has been rising since 2000 and, as of 2012, was 42% higher than the national average. This figure does not include those who access PAS.[68] Jones and Paton (2015) state,

> Legalising PAS has been associated with an increased rate of total suicides relative to other states and no decrease in non-assisted suicides. This suggests either that PAS does not inhibit (nor acts as an alternative to) non-assisted suicide, or that it acts in this way in some individuals but is associated with an increased inclination in suicide in other individuals (p599).[69]

d. Change in the nature and direction of medicine

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[63] Boer, T. 2014. Quoted in "Rushing toward death. Euthanasia in the Netherlands." Accessed 13 Feb 2019 at http://www.noeuthanasia.org.au/rushing_toward_death_euthanasia_in_the_netherlands. Para. 11-15.
[64] de Bellaigue, C. (n51)
[65] Ibid
[66] Hendin and Foley (n16)
[67] Doerflinger, R. 2017. "The effect of legalising assisted suicide on palliative care and suicide rates: A response to compassion and choices." Accessed on 13 Feb 2019 at https://lozierinstitute.org/the-effect-of-legalizing-assisted-suicide-on-palliative-care-and-suicide-rates/
[68] Ibid
[69] Jones, D.A. and D. Paton. 2015. "How does legalisation of physician-assisted suicide affect rates of suicide?" Southern Medical Journal; 108:10. P599.

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Euthanasia and PAS laws change the nature of medical practice, defining euthanasia as a medical intervention and giving physicians the ability to write prescriptions and in some cases administer life-ending drugs. Both the World Medical Association (WMA) and the Australian Medical Association (AMA) oppose euthanasia and PAS.[70] The AMA states that it agrees with the WMA in that, "it is opposed to doctors being involved in interventions that have a primary intention of ending a person's life" (para. 4).[71] The AMA does note the differing viewpoints within the medical profession.

The Christian Medical & Dental Fellowship of Australia, Inc. has stated, "The successful doctor-patient relationship depends on a high level of trust, which would be eroded if the doctor could not be depended on to preserve life" (point 8).[72] To this effect Sulmasy et al (2016) note, "Medicine and the medical profession traditionally aimed at curing and healing, assisting in a suicide is neither cure nor healing. It pits the medical profession against itself: curing and caring versus killing" (p254).[73]

Review of Victorian legislation and proposed legislation in NSW

Victoria's Voluntary Assisted Dying Act

Victoria passed its Voluntary Assisted Dying Act in 2017 becoming the first state in Australia to have PAS legislation. The legislation in Victoria permits an adult, who has been diagnosed with a terminal illness and has less than 12 months to live, to request and access life-ending medication. Only the patient can initiate the request, and this must be done on three separate occasions. The patient must also have two independent medical assessments. There is one pharmacy in Victoria responsible for dispensing the medication, and the VAD Review board is responsible for overseeing the operation of the law.[74] Victoria's legislation is considered the strictest in the world.

As per Victoria's legislation:

[70] AMA Tasmania. 2 Jan. 2020. "Euthanasia, Voluntary Assisted Suicide (VAS), and Physician Assisted Suicide (PAS)" Accessed on 04 August 2021 at https://tas.ama.com.au/tas/euthanasia-voluntary-assisted-suicide-vas-and-physician-assisted-suicide-pas
[71] Australian Medical Association. 28 Oct. 2017. "Euthanasia and physician assisted suicide." Accessed on 25 May 2019 at https://ama.com.au/media/euthanasia-and-physician-assisted-suicide. Para. 4.
[72] Best, M. Christian Medical & Dental Fellowship of Australia, Inc. 2017. Email. "Euthanasia Legislation in NSW." Point 8.
[73] Sulmasy et al. (n10) (p254)
[74] Minister for Health. 5 January 2019. "Voluntary assisted dying a step closer." Accessed at https://www.premier.vic.gov.au/voluntary-assisted-dying-a-step-closer. Accessed on 27 May 2019.

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- "The person must be diagnosed with a disease, illness or medical condition that is incurable, advanced or progressive and will cause death, and is expected to cause death within less than 12 months" (para. 21).
- "The person must be experiencing suffering that cannot be relieved in a manner that the person considers tolerable" (para. 22).
- "A person is not eligible for access to voluntary assisted dying if they have a mental illness only, or if they have a disability only" (para. 23).
- "It is also not possible for a person to make a statement to request voluntary assisted dying in an advanced care directive" (para. 24). [75]
- Once a person is given the life-ending medication, they can ingest it without a doctor or health practitioner present.[76]

Those medical practitioners who assist in the process are protected from criminal and civil liability if they act in accordance with the legislation.[77]

Since Victoria's VAD legislation came into effect in 2019, 220 people in Victoria have died through VAD or euthanasia (as of May 2021).[78] As of June 2020, where 124 people in Victoria had died through VAD and euthanasia, the number of people dying this way was 10 times the number anticipated by the Victorian Health Minister.[79] In its third report (July through December 2020), Victoria's VAD Review board reported that the number of practitioner administration permits to VAD increased by 31.6% in that time period (Note the fourth report is due in August 2021).[80] As of December 2020,

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[75] Parliament of Victoria. "Voluntary assisted dying bill 2017." Accessed at https://www.parliament.vic.gov.au/publications/research-papers/download/36-research-papers/13834-voluntary-assisted-dying-bill-2017. Accessed on 27 May 2019.
[76] Victoria State Government. "Preparing to take the medications." Accessed at https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/community-consumer-information/voluntary-assisted-dying-process/preparing-to-take-medications. Accessed on 16 August 2021.
[77] Ibid
[78] ABC Radio National. 7 May 2021. "It's been two years since Victoria introduced assisted dying laws, so how well are they working?" Accessed at https://www.abc.net.au/news/2021-05-07/voluntary-euthanasia-laws-how-well-are-they-working/100117058. Accessed on 16 August 2021.
[79] Bowling, M. 5 September 2020. "Victoria reports ten times as many deaths as anticipated in first twelve months from VAD and euthanasia." Accessed at https://catholicleader.com.au/news/victoria-reports-ten-times-as-many-deaths-as-anticipated-in-first-12-months-from-vad-and-euthanasia/. Access on 16 August 2021.
[80] Voluntary Assisted Dying Review Board. July-December 2020. "Report of Operations: July-December 2020." Accessed at https://www.bettersafercare.vic.gov.au/sites/default/files/2021-02/VADRB_Report%20of%20operations%20Feb%2021_FINAL.pdf. Accessed on 16 August 2021.

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the average age of a VAD applicant was 71 years old and the majority of applicants accessing VAD had terminal cancer.[81]

There have been some complaints around the difficulty of patients accessing information about VAD in Victoria, as the legislation does not allow for medical professionals to bring it up with eligible patients. The Victorian VAD Review board has said it will monitor legislation in WA, where medical professionals are allowed to bring up the topic, to see if changes should be made to Victoria's legislation.[82]

NSW Voluntary Assisted Dying Bill 2017

In 2017, NSW tried to pass VAD legislation for adults over the age of 25 with a "terminal illness, severe pain, suffering or physical incapacity to an extent unacceptable by the person" (p.2).[83] This proposed legislation built in some protections around abuse of the patient by assessing whether there could be financial gain by a family member. It also required that there be two medical examinations and examination by a qualified psychologist/psychiatrist prior to approving a VAD request.[84] Victoria's legislation is said to be tougher than NSW's 2017 Bill because of the level of oversight involved in the process.[85] NSW's 2017 VAD Bill was defeated by one vote in the Upper House.[86]

The 2021 Greenwich Bill

In July 2021, Alex Greenwich, MP released a draft VAD Bill with the intention of introducing it in the NSW legislature in October 2021. This Bill allows access to VAD for adults (aged over 18) who have been diagnosed with "at least one disease, illness or medical condition that -

- is advanced, progressive and will cause death and
- will, on the balance of probabilities, cause death –

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[81] Ibid
[82] Ibid
[83] Introduced by Khan, Trevor, MLC. 2017. "Voluntary Assisted Dying Bill 2017." Accessed at https://www.parliament.nsw.gov.au/bills/Pages/bill-details.aspx?pk=3422. Accessed on 27 May 2019.
[84] Ibid
[85] Bonython, W. and Bruce Baer Arnold. 16 Nov. 2017. "The NSW assisted dying bill isn't as robust as Victoria's model." Accessed at https://theconversation.com/the-nsw-assisted-dying-bill-isn't-as-robust-as-victorias-model-87261. Accessed on 27 May 2019.
[86] Nicholls, S. 16 November 2017. "Voluntary Assisted Dying Bill defeated in NSW Upper House." Accessed at https://www.smh.com.au/national/nsw/voluntary-assisted-dying-bill-defeated-in-nsw-upper-house-20171116-gzn25g.html. Accessed on 16 August 2021.

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- For a disease, illness or medical condition that is neurodegenerative, within a period of 12 months, and
- Otherwise, within a period of 6 months

- or is causing suffering to the person that cannot be relieved in a way that the person considers tolerable (pg. 6, section d)."[87]

The person requesting VAD must have decision-making capacity and not be under pressure or duress (pg. 6, sections e and f).[88] If the consulting medical practitioner is not certain about the person's decision-making capacity or duress, the practitioner must refer the person to a psychiatrist or other health practitioner for assessment.

Under the proposed Bill, medical practitioners, registered nurses, and healthcare workers can initiate a conversation about VAD. They must also give information about other treatment options and/or palliative care options, and healthcare workers must refer the patient to a doctor.[89]

The person requesting VAD can make the request known verbally with or without a translator, via written communication, or using gestures. This request can occur in-person or via Telehealth. Upon acceptance of the initial request, the person needs to make their request known to a second medical practitioner. Neither of the two medical practitioners are required to be specialists in the person's condition and the medical practitioners do not have to be independent of one another (meaning they could work at the same practice). The minimum time frame between the two requests is five business days unless the person is likely to die or become incapacitated within that five-business day period, when the waiting period could be reduced.[90]

The person requesting VAD does not need to be assessed for mental illness but is not eligible for VAD through disability or mental illness alone. Upon acceptance of the first request for VAD, the medical practitioner must also offer information about various treatment options, palliative care and the potential risks involved in self-

[87] Draft Bill to NSW Legislature. Greenwich, A. MP. Voluntary Assisted Dying Bill. 2 July 2021. Accessed at https://cdn-au.mailsnd.com/81257/fW3i37664wr3u5hLRqDBDM6f0kJO4aiVdUcAJh8LfJ4/2618115.pdf. Accessed on 8 September 2021.
[88] Ibid
[89] Greenwich, A. MP. Summary of Substantial Amendments to the Voluntary Assisted Dying Bill 2021 Consultation Draft. Accessed at https://d3n8a8pro7vhmx.cloudfront.net/alexgreenwich/pages/10344/attachments/original/1632369375/Summary_of_Substantial_Amendments_Since_Consultation_Draft_.pdf?1632369375. Accessed on 27 Sept 2021.
[90] Ibid

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administering or being administered the life-ending medication. Upon the death of the individual who accessed VAD, the medical practitioner must make no reference to VAD on the death certificate.[91]

Health professionals can object to participating in any or all of the VAD process, but aged care facilities (and other health facilities) must allow for access either offsite or onsite for all parts of the VAD process to occur. The health facility does not have to provide the services itself.[92]

Although it is good to see safeguards and oversight in Victoria's Death with Dignity Act and similar safeguards in NSW's Voluntary Assisted Dying Bill, the concerns raised previously in the paper still stand. When a law is built around something as subjective as "suffering that cannot be relieved in a manner that a person considers tolerable", that legislation can be loosened.[93] Why is suffering at the end-of-life worse than the suffering someone experiences from disease that is not life-ending? No person at the end-of-life should be left to die in intense pain. This is a failure of palliative care and efforts should be put towards funding quality and robust palliative care services in all locations.

Despite the best efforts of both pieces of legislation to protect people from abuse, it is still impossible to fully know what happens behind closed doors with close friends and family. As discussed previously, it is very difficult to protect people from feeling that they are a burden to loved ones and should end their lives so as to not cause pain to those around them.

Both bills change the definition of medicine to allow a doctor to assist in ending a person's life. The bills also change criminal and civil law so that those involved in the death are not held liable for murder. It is impossible to know fully the effects that these changes will have now and in the future for those in the medical profession. Victoria's legislation and NSW proposed Bill are both open to the concerns raised earlier around avoidable suffering, abuse, slippery slope and the changing nature of medicine.

Conclusion – Where to from here?

With a topic as emotive as euthanasia, it is easy to become focused on the public debate and what is reported in the media. While still being able to speak into the public space, Christians can focus on caring for people at the end-of-life and caring for their carers. They can examine what it means to have a good death, promote

[91] Ibid
[92] Ibid
[93] Parliament of Victoria. (n69) (para. 22)

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having open conversations around death in their communities, and speak up for holistic palliative care services. In Dying Well, Swerissen and Duckett (2014) say, "When dying is not discussed and concerns about voluntary euthanasia and assisted dying cloud the debate, the quality of death is poorer" (p11).[94]

According to "Dying Well", a good death is:

- To know when death is coming, and to understand what can be expected
- To be able to retain control of what happens
- To be afforded dignity and privacy
- To have control over pain relief and other symptom control
- To have choices and control over where death occurs (at home or elsewhere)
- To have access to information and expertise of whatever kind is necessary
- To have access to any spiritual or emotional support required
- To have access to hospice care in any location including home, not only in hospital
- To have control over who is present and who shares the end
- To be able to issue advance directives that ensure wishes are respected
- To have time to say goodbye, and control over other aspects of timing
- To be able to leave when it is time to go, and not to have life prolonged pointlessly

In light of the above, what are some things that Christians can do to care for people at the end-of-life?

- Have open and honest conversations about death in church communities. Listen to peoples' fears and concerns about death. Help people think through the meaning of their lives and the fear they may have about what will happen when they are dying.
- Talk to their loved ones about Advanced Care Directives where they can clearly lay out their wishes for the end of their lives. Advanced Care Directives also prevent life-sustaining treatments being used unnecessarily.
- Prioritise providing practical support for people at the end of their lives and for their carers.
- Become informed about what palliative care can offer at the end-of-life and advocate for increased funding for holistic palliative care, including in-home palliative care services.

[94] Swerissen H. and S. Duckett. 2014. "Dying Well". Grattan Institute Report No. 2014-10, September 2014.

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- Advocate for more education around palliative care. The more physicians know about palliative care, the less likely they are to support euthanasia and PAS.
- Become trained as a pastoral care volunteer and support ageing and vulnerable Australians.

Dr. Megan Best, medical ethicist and palliative care physician has said,

> I wonder if our community discussion about euthanasia is not so much about pain control as a desire to control dying itself. We do not need a 'right to die' – death is coming to each of us all too predictably, and modern autonomous man is not ready. We have lost our traditions, we don't know how to die, we have lost our vocabulary to discuss the existential questions which death demands of us – why are we here, what is it all about, where are we going (para. 26)?[95]

Christian communities can regain their vocabulary around death. Church communities can become centres of excellence, where those people at the end-of-life and their carers are supported and protected.

[95] Best, M. 2010 Feb 10. ""Euthanasia."
https://www.publicchristianity.org/euthanasia/?_sf_s=euthanasia&_sft_media=article. Para. 26

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Glossary of Terms

Euthanasia: Generally used to describe the process of intentionally terminating a person's life to reduce their pain and suffering.[96]

Active voluntary Euthanasia: When medical intervention takes place, at the patient's request, in order to end the patient's life.[97]

Passive voluntary Euthanasia: When medical treatment is withdrawn or withheld from a patient, at the patient's request in order to end the patient's life [98] (Palliative experts would prefer that this term not be used as they say withholding or withdrawing treatment is not a form of euthanasia).

Palliative Care: Person and family-centred care provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure and who expected to die, and for whom the primary goal is to optimise the quality of life.[99]

Physician Assisted Suicide (PAS): The voluntary termination of one's own life by the administration of a lethal substance with the direct or indirect assistance of a physician.[100]

Voluntary Assisted Dying (VAD): Allows a person at the late stages of advanced disease to take a medication prescribed by a doctor that will bring about their death in a time they choose.[101]

Advocates of assisted dying prefer the term Voluntary Assisted Dying (VAD) to Physician Assisted Suicide (PAS).

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[96] Australia Human Rights Commission. 2016. "Euthanasia, human rights and the law." Accessed on 27 March 2019: https://www.humanrights.gov.au/our-work/age-discrimination/publications/euthanasia-human-rights-and-law
[97] Ibid
[98] Ibid
[99] Palliative Care Australia. "What is palliative care?" Accessed on 27 March 2019: https://palliativecare.org.au/what-is-palliative-care
[100] MedicineNet. "Medical definition of physician assisted suicide." Accessed on 27 March 2019: https://www.medicinenet.com/script/main/art.asp?articlekey=32841
[101] Victoria State Government: Better Health Channel. 2018. "Voluntary Assisted Dying." Accessed on 27 March 2019. https://www.betterhealth.vic.gov.au/health/servicesandsupport/voluntary-assisted-dying