Euthanasia: Patient Autonomy Versus the Public Good

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The euthanasia debate has raised a myriad of ethical and social issues, such as the right to life, the avoidance of unnecessary pain, and the proper allocation of medical resources. This paper examines whether active euthanasia will secure individual autonomy without an overall detriment to the public good. In the context of the overall debate this is a narrow, but arguably defining issue, for it sets off the chief competing arguments that have been advanced.

1. Introduction

(i) Overview

The *Rights of the Terminally Ill Act (Northern Territory)* 1995 (the Act)[1] was the first piece of legislation anywhere in the world to legalise euthanasia,[2] and was the catalyst for widespread debate, the breadth, intensity and ferociousness of which is almost unprecedented in the normally dispassionate and nonchalant Australian community.

The controversial nature of the euthanasia issue is readily apparent from the fact that it is illegal throughout Australia and constitutes murder, despite public opinion appearing to pointedly favour it: most polls indicate that the level of support runs at about three quarters of the population.[3]

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1 The Act was assented to on 16 June 1995 and proclaimed on 1 July 1996. The principal objective of the Act was to legalise euthanasia by providing legal immunity to doctors.

2 Although active euthanasia is openly practiced in the Netherlands this is due to a non-prosecution stance based on the presumption that a doctor is entitled, and indeed has a duty, to relieve suffering.

3 A relatively recent poll indicated that 78% of Australians approve of active euthanasia: see M Charlesworth, 'Dying and the Law' (1995) 4(2) *Res Publica* 12, 15. This result is consistent with submissions to the Northern Territory Select Committee on Euthanasia where 72% of the total submissions (1126) favoured euthanasia (see, Legislative Assembly of Northern Territory, *Report of the Inquiry by the Select Committee on Euthanasia* (1995) Vol 1 (henceforth this report will be referred to as The Report by the Northern Territory Select Committee on Euthanasia) at

The repeal of the Act,[4] has done nothing to quell the debate on what is probably the most pressing moral issue of our time.[5]

Euthanasia raises many important moral and social issues including the sanctity of life, the avoidance of unnecessary pain and the appropriate allocation of medical resources. The argument championed most powerfully by euthanasists is the argument from personal autonomy. This article will focus on whether the decriminalisation of active voluntary euthanasia will secure individual autonomy without an overall detriment to the public good. In the context of the overall debate this is a narrow but defining issue, for it sets-off the chief competing arguments.

The issue at hand is particularly important from the perspective of those opposed to euthanasia.[6] By generally employing the bad consequences argument as their main sword, surprisingly many of them, perhaps inadvertently, have surrendered considerable ground and dug their trenches further back than was logically necessary. The starting

31). The results of a comprehensive range of surveys regarding euthanasia are detailed in the Report of the Senate Legal and Constitutional Legislation Committee, Parliament of Australia, *Euthanasia Laws Bill 1996*, (Canberra, 1997), 81-92. See also M Otlowski, note 3 above, pp 257-267, for further poll results on the issue. Most recently, the results of a survey conducted in the Northern Territory (during the period when the Northern Territory permitted euthanasia) showed that 73 % of the community supported euthanasia: *The Age*, 'Euthanasia Poll Shows Divided Attitudes in NT', 26 February, 1999, p 2.

4 By the *Euthanasia Laws Act* 1997 (Cth).

5 For example, on 26 November 1998, Dr Nitschke provocatively admitted on Melbourne Radio that he helped 15 people to end their lives since the Act was overturned (*The Age*, 'Doctor: I Helped 15 Patients Die', 27 November 1998, p 1).

6 Even if the autonomy argument proves to be unpersuasive this is not necessarily fatal to euthanasists, since they also have another powerful argument in their armoury, namely the 'argument from compassion' which asserts that euthanasia is the kind thing to do and that prohibitions that force a dreadful, painful death on rational but incapacitated terminally ill people are an affront to human dignity (*Rodriguez v A-G British Columbia* [1993] 3 CSCR 519, Gray J). However, the emotive appeal of this argument has been gradually eroded away by empirical evidence that in about 95% of cases of terminal illness pain can be abolished and in the other 5% it can be partly relieved (Doyle, Hanks and McDonald (eds), *Oxford Textbook of Palliative Medicine* (1993)). For further data, generally in line with this see House of Lords, *Report of the Select Committee on Medical Ethics* (1994) vol. 1 (henceforth referred to as House of Lords Report on Medical Ethics (1994), 33-34, which concluded that the pain and distress of terminal illness can be adequately relieved in the vast majority of cases, and M Asby, 'Hard Cases, Causation and Care of the Dying' (1995) 3 *JLM* 152, 155; but cf J Hockley et al, 'Survey of Distressing Symptoms in Dying Patients and their Families in Hospital and the Response to a Symptom Control Team' (1988) 296 *BMJ* 1715. The argument from compassion can also be equally used to favour the further development of palliative care as it can to condone euthanasia (for example, see House of Lords Report on Medical Ethics (1994) 49).

point for those opposed to euthanasia should have been to press that euthanasia is wrong in itself and to then rely on possible incidental bad consequences to buttress their stance. This is especially so given the ostensibly strong argument, which appears to have been ignored by all except the Catholic Church, that all human life is sacred and inviolable due to the *inherent* value it possess[7] and therefore any loss of life is undesirable; whether or not this may result in other bad consequences. There is a significant difference between an act being intrinsically wrong and contingently wrong due to bad consequences that may follow from it. Once opposition to a practice is grounded merely in possible associated adverse side-effects, the door is left wide open for advocates of the practice to irresistibly press their case by implementing safeguards nullifying the possible collateral harm. Accordingly, given the current position of the debate it is imperative for anti-euthanasists to show potent reasons why euthanasia will negatively affect public good in a manner which is not readily guarded against.

(ii) Definitions - Euthanasia, Autonomy and Consent

Euthanasia means 'killing someone, on account of his [or her] distressing physical or mental state, where this is thought to be in his [or her] own interests'.[8] Voluntary euthanasia is when the ill person has expressly manifested a desire to be killed. Active voluntary euthanasia

7 For example, see The Linacre Centre, *Submission to The Select Committee of the House of Lords on Medical Ethics* (1993) 119, where it was stated that the distinctive feature which makes human beings so special is dignity 'which belongs to all of them in virtue of a radical capacity inherent in their nature'. In a similar vein, the 1988 Report by the London, British Medical Association On Euthanasia (*Euthanasia, Report of the Working Party to Review the British Medical Association's Guidance on Euthanasia*, May 1988) stated that the main reasons euthanasia should not be legalised are that it would detract from the supreme value of the individual, no matter how worthless and hopeless that person may feel, and the repugnance in the view that someone would be better off dead which merely represents arbitrary choices about the worth that attends a life. See also M Brown, 'Patient's Consent' (1993) 18/19 *Law and Justice* 21 for an outline of the traditional Catholic position.

8 This is the definition adopted by J Glover, in *Causing Deaths and Saving Lives* (Penguin Books, 1977) p 182. The literature in this area is rife with self serving definitions of euthanasia. For example, euthanasia has been defined as deliberately killing a person out of *kindness*' (Report by the Northern Territory Select Committee on Euthanasia, 5) and 'assisting a person to die in a *humane* manner' (R Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, Individual Freedom* (Knoph, 1993) p 3). Such definitions are objectionable because they can be used to gain an undeserved definitional edge. Use of emotive terms such as *kindness* and *humane* risks deflecting the focus of the debate from rationality to rhetoric and propaganda. To avoid definitional bias I have adopted the above 'neutral' definition.

(which is the focus of this paper) refers to the taking of direct action, such as inflicting a lethal injection, to kill someone who has expressed a wish to die.[9]

Literally, autonomy means 'self-government' and people are autonomous 'to the extent to which they are able to control their own destiny, by the exercise of their own faculties',[10] or 'exercise individual liberty to do as they please'.[11] However no right is absolute,[12] hence

9 There are three other forms of euthanasia. Merely refraining from action which will prolong life, such as opting not to provide sustenance, is passive euthanasia. The most common basis upon which a distinction is sought to be made between active and passive euthanasia is the acts and omissions doctrine. However, this is unpersuasive, because ultimately it is morally irrelevant whether a course of conduct is labelled as an act or omission; the test being whether one has discharged *all* of his or her moral obligations. However, a distinction between active and passive euthanasia is found in the respect accorded to physical integrity. In order for a doctor to desist from participating in passive euthanasia, he or she must provide treatment against the patient's express wishes, thereby violating the patient's physical autonomy (see M Bagaric, 'Active and Passive Euthanasia: Is There a Moral Distinction and Should There Be a Legal Difference' (1997) 5(2) *JLM* 143, 153-4). Voluntary euthanasia is distinguished from non-voluntary euthanasia which is defined as 'killing someone ... where he is either not in a position to have, or not in a position to express, any views on' whether he would wish to be killed (see Glover, note 8 above, p 191); and involuntary euthanasia, which is killing against one's express wishes. Neither involuntary nor non-voluntary euthanasia can rely on most of the arguments which are customarily used to support euthanasia (such as the respect for personal autonomy) and are almost universally condemned. Although, see J Rachels in *The End of Life: Euthanasia and Morality* (Oxford University Press, 1986) p 159, where he argues that many people have less difficulty accepting non-voluntary euthanasia than voluntary euthanasia - presumably because in cases of non-voluntary euthanasia the patient often has such a poor quality of life that it may seem to be in his or her best interests to not prolong life. I do not believe that this is a persuasive assumption; surely it depends on the precise medical condition and the tenacity that the individual concerned has for life.

10 J Harris, *The Value of Life: An Introduction to Medical Ethics* (Routledge, 1985) p 195.

11 J Finnis, 'Living Will Legislation', L Gormally (ed), *Euthanasia, Clinical Practice and The Law* (Linacre Centre, 1994) pp 167, 171.

12 Even R Dworkin, perhaps the leading deontological rights philosopher, who urges us to take rights ever so seriously, accepts that it is appropriate to infringe on a right when it is necessary to protect a more important right, or to ward off some great threat to society (R Dworkin, 'What Rights Do We have?', *Taking Rights Seriously* (Duckworth, 1978) p 213). Similarly, R Nozick, another leading rights proponent, acknowledges that consequentialist considerations would take over to avert moral catastrophe (R Nozick, *Philosophical Explanations*, (Oxford University Press, 1981), p 495). The fact that no right is absolute is evidenced by the extreme and fanciful lengths that some have gone to in order to justify a claim to the contrary. For example, A Gerwith, in *Human Rights: Essays on Justifications and Applications* (1982), pp 232-3, in search of an absolute right, states that the right of a mother to not be tortured to death by her son is absolute. However, even such

the most appropriate definition of autonomy is the right to exercise one's personal liberty free from arbitrary or otherwise unjustified interference.

Consent has no precise meaning and varies according to the branch of law in question.[13] However in most contexts it requires at least three elements: the physical power to consent, rationality, and voluntariness.[14] It also involves a concurrence of the wills,[15] and in this way differs from autonomy. Consent is a species of, and obtains its moral force from, the concept of autonomy. It relates to situations where exercise of autonomy requires or involves the participation of another in order to fulfil the particular desire. This distinction is not significant in the case of euthanasia. The interests of the other party in the practice, health professionals, are extremely peripheral and it has never been seriously suggested that the efficacy of decriminalising euthanasia may be at risk due to an inability in finding willing health professionals. Accordingly it matters very little whether the foregoing discussion is framed in terms of autonomy or consent. In keeping with the theme and the nomenclature used in the euthanasia debate I will generally use the term autonomy: however it is important to bear in mind that in the context of this discussion it is effectively synonymous with consent.

(iii) Current Legal Position

At law, active euthanasia is murder: 'if the acts done are intended to kill and do, in fact, kill it does not matter if a life is cut short by weeks or months, it is just as much murder as if it were cut short by years'.[16] Consent of the patient is not a defence to serious injury or death[17] and therefore is not a basis upon which culpability can be avoided in cases of euthanasia. In 1992, Ognall J emphatically stated that there is an '*absolute* prohibition on a doctor purposefully taking life (emphasis added)'.[18]

extreme examples fail. One could hardly begrudge a son torturing his mother to death if this was the only means to save the lives of his innocent relatives whom the mother was about to execute.

13 *Whittaker v Campbell* [1984] QB 318.

14 For example, see *Criminal Code Act* 1924 (Tas), s24.

15 For example, see *Huntley v Hott* 20 A. 449; 9 LRA 111 (1890).

16 H Palmer, 'Dr Adams Trial for Murder' [1957] *Crim LR* 365.

17 *R v Brown* [1993] 2 WAR 556. See also *Airedale NHS Trust v AC Bland* [1993] AC 789 (*Bland*).

18 *R v Cox* (1992) 12 BMLR 38. Dr Cox killed his terminally ill patient, and friend, who had expressed a wish to die by injecting her with potassium chloride (which

To provide medical treatment against a patient's wishes can constitute both a tort and a criminal assault.[19] Thus the common law recognises that a patient may refuse life saving or life sustaining medical treatment even when it is certain that death will follow.[20]

has no therapeutic or analgesic effect) and was found guilty of murder. Most recently, in 1993, the House of Lords in *Airedale NHS Trust v Bland* [1993] AC 789 confirmed that it is unlawful to take active measures to shorten the life of a terminally ill patient by directly intentionally killing the patient. In *Bland*, the House of Lords upheld the decision of the Court of Appeal that it was lawful to discontinue the medical treatment of a 20 year old patient who had been in a permanent vegetative state for over three years with no hope of improvement. Bland's continued existence was dependent on the taking of steps such as nasogatric feeding. It was held that feeding by this method was medical treatment rather than palliative care and its withdrawal an omission as opposed to an act. Thus in effect the House of Lords condoned passive non-voluntary euthanasia. It is interesting to note the confusion and unpersuasiveness of some of the judgements. For example, Bingham MR in the Court of Appeal, at 808, stated that since this had nothing to do with taking positive action to cause death it was not a case of euthanasia. Further, it was generally agreed that central to the outcome of the case was the characterisation of the relevant procedure as an omission, rather than an act: however none of the judgements provided a sound reason for the significance of this distinction. Lord Goff, at 865, stated that 'the drawing of the distinction may lead to a charge of hypocrisy'; Lord Browne-Wilkinson, at 885, stated that distinguishing between acts and omissions may 'appear to some to be irrational'; and Lord Mustill, at 887, stated that acts and omissions are 'for all relevant purposes indistinguishable' and to adopt the distinction is 'only to emphasise a legal structure which is already both morally and intellectually misshapen'. For an excellent analysis of *Bland* see J M Finnis, 'Bland: Crossing the Rubicon?' (1993) 109 *LQR* 329.

19 *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.

20 *Re T (Refusal of Medical Treatment)* [1992] 3 WLR 782, and *Bland*. This is so even where the refusal appears irrational (*Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, 904-5). This is not to say however that the common law condones suicide. Where it is certain that a refusal to accept treatment will result in death, the legal position is that this does not constitute suicide where the reason for the refusal is other than to die. For example a Jehovah's witness who refuses a life saving blood transfusion for religious reasons, or a terminally ill patient who has lost hope and believes treatment offers no benefit are not regarded as wishing to die (D Lanham, *Taming Death by Law* (Longman Professional Publishing, 1993) ch 2). The right to refuse medical treatment is given statutory effect by Section 5 of the *Medical Treatment Act* 1988 (Vic), which provides that a person of sound mind over 18 years old may refuse medical treatment. This applies in relation to all medical conditions, whether terminal or not. While the Act permits patients to refuse medical treatment it does not cover a refusal to receive palliative care, which includes the provision of food and water and reasonable medical procedures for pain relief (section 3). The *Medical Treatment Act* 1988 (Vic) does not confer a right to refuse medical treatment where the medical condition stems from an attempt to commit suicide and compliance with the patient's request would complete the suicide attempt (*Re Kinney*, unreported, Supreme Court of Victoria, Fullagar J, 23 December 1988). Although suicide is no longer unlawful (*Crimes Act* 1958 (Vic), s6A) it is still a crime to assist others to kill themselves (*Crimes Act* 1958 (Vic),

Acceptance of this principle and the fact that health professionals are only required to provide ordinary, as opposed to extraordinary,[21] treatment has allowed the medical profession to effectively practice passive euthanasia with impunity.[22]

2. The Threshold Issue: Whether Euthanasia Secures Individual Autonomy?

In its simplest and most powerful form the argument from autonomy is that it is an unjustifiable encroachment upon individual liberty to prevent a competent terminally ill patient and a co-operative doctor from acting upon the patient's desire to end life.[23] The euthanasia catch phrase of 'the right to die with dignity'[24] stems from the right to autonomy.[25]

s6B(2)) and it is permissible to use reasonable force to prevent suicide (*Crimes Act* 1958 (Vic), s463B).

21 The distinction between ordinary and extraordinary treatment was given expression by Pope Pius XII in 1957 (1957) 49 *Acia Apostolicae Sedis* 1027) and was endorsed in *Bland* 879, 893. However, it also has many critics, for examples see M A Somerville, 'Death Talk in Canada: The Rodriquez Case' (1994) 39 *McGill LJ* 602.

22 The decision in *Bland* will no doubt reinforce this practice. For a fuller discussion regarding the legal status of euthanasia see my earlier discussion: Bagaric, note 9 above, at pp 145-7.

23 For example, see H Kuhse and P Singer, 'Active Voluntary Euthanasia, Morality and the Law' (1995) 3 *JLM* 129, at p 131.

24 The 'right to die' however is questionable. As has been pointed out, what the 'advocates of euthanasia are in fact claiming is ... two different rights, namely the right of someone to be killed on request in certain circumstances, and the right of others to respond to that request by killing them', neither of which exist in our society (B Pollard, *Euthanasia: Should We Kill the Dying* (Bedford: Mount Series, (1989), p 53). See also A Sloane, 'A Community Should Care, not Kill', *The Age* (10 October 1996) p 15.

25 Still the most persuasive statement regarding the paramountcy of autonomy and liberty is that by the utilitarian philosopher John Stuart Mill who stated that 'the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. The only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant (J S Mill, 'On Liberty', M Warnock (ed), *Utilitarianism* (Fontana Press, 1986, first published 1859) pp 126, 135). More recently, Lord Mustill in a dissenting judgement in *R v Brown* [1993] 2 WLR 556, 600, endorsed the central role of personal liberty, effectively stating all autonomous acts should be permitted unless there is good reason to the contrary. Mill's statement on liberty has been criticised most heavily on the basis that the grounds for legitimate interference with individual liberty extend beyond prevention of harm to others. Clearly, our legal system which compels us to do such things as wear safety helmets when riding a push bike and seat belts in cars

Despite advances in palliative care it is still the case that some people endure slow, painful and demeaning exits[26] and it is claimed that 'making someone die in a way that others approve, but he regards as a horrifying contradiction to his life is a devastating odious form of tyranny'.[27] Decriminalising euthanasia will permit patients to choose the time and manner of their death, and hence it may seem futile to seriously question whether euthanasia will actually secure patient autonomy in a clear and meaningful manner. But if one looks even a little below the surface it seems that the advances in autonomy promoted by euthanasists may not be as dazzling as is claimed.

(i) The Extent to Which Euthanasia Actually Advances Autonomy

Before inquiring into any possible disadvantages that may flow from euthanasia it is imperative not to be 'blinded by the light' and to retreat momentarily to the threshold issue of the extent to which euthanasia actually promotes autonomy. An autonomous decision is one that is made freely and rationally. Absent either of these conditions the authority and legitimacy of a decision is vitiated.

A terminally ill patient is at the lowest point of his or her life and a decision to die is by its very nature made in oppressive circumstances. We can never be sure that such a wish is rational and free due to the possibility it was improperly influenced by depression,[28] confusion, dementia, suffering, a feeling of being burdensome to others, or a drain on health resources.[29] Thus it can be argued that although in normal circumstances it is safe to assume that an agent's autonomy has been respected when his or her desire has been satisfied, the circumstances in which a wish to die is normally made are generally so arduous that this presumption is displaced.[30] To claim that euthanasia

does not appear to adopt Mill's position; however for the purposes of this paper I shall accept that autonomy is a highly desirable virtue.

26 Normally due to the unavailability of adequate palliative care.

27 Dworkin, note 8 above, p 46.

28 Empirical evidence suggests that many, if not most, terminally ill patients experience depression of some form, and that it will usually be impossible to exclude a depressive illness as an influence in the decisions of the terminally ill (P E Mullen, 'Euthanasia: An Impoverished Construction of Life and Death' (1995) 3 *JLM* 121, at p 126, and J H Brown et al, 'Is it Normal for Terminally Ill Patients to Desire Death' (1986) 143(2) *Am J Psychiatry* 208).

29 *Submission by HOPE* to House of Lords Select Committee on Medical Ethics, vol. II pp 105, 107.

30 I am ignoring the argument that, due to empirical evidence that most suicide survivors come to welcome their failure (British Medical Association, *Euthanasia, Report of the Working Party to Review the BMA's Guidance of Euthanasia* (London, 1988), and a suspicion that pleas to be killed are often no more than 'covert pleas

secures autonomy *only* because the wish to die is fulfilled is at best a cheap victory.

Autonomy does not always equal doing as one ostensibly wishes. Often when a decision is made in extreme circumstances the law accepts that a person's freedom of will and powers of reason have been totally or partially usurped or overwhelmed and does not hold the person fully accountable for the consequences of his or her acts; the decision is not regarded as being fully autonomous, despite the overt voluntariness of the conduct. Thus duress is a defence to a criminal charge[31] and a person who acts under extreme temptation,[32] provocation[33] or emotional distress[34] is given a discounted sentence. A decision to die is made in even more trying circumstances and we should be similarly guarded in accepting that it is fully autonomous, despite its veneer of voluntariness. It may well be that in such cases the decision maker requires protection, not acquiescence. Indeed one would think that the oppressiveness in which a wish to die is normally communicated is far more overwhelming than circumstances in which courts have previously held that the will of a person may be overborne. For example, in *Collins v R*[35] it was noted that a person's will can be overborne by such matters as social condition, environment, natural timidity and subservience. To assert that euthanasia promotes autonomy to any meaningful extent it must be shown that measures have been taken to ameliorate the burdensome and potentially overwhelming conditions in which the choice to die has been expressed,[36] otherwise at its highest only submission rather than consent can be claimed.[37]

for considerate and committed care' (L Gormally, 'The BMA Report on Euthanasia and the Case Against Legislation, in L Gormally (ed), *Euthanasia, Clinical Practice and The Law*, (Linacre Centre, 1994) pp 177, 180), a desire to die of its own evinces irrationality. Ultimately, we cannot dismiss the wish to die as been self-evidently irrational, for unlike the suicide survivor the terminally ill patient's outlook has little prospects of improvement and there is accordingly less likelihood of a change in mind.

31 *R v Lawrence and Others* (1980) 32 ALR 71.

32 *Masciantonio v R* (1995) 129 ALR 575.

33 *R v Stanley* (Unreported 24/6/88 CCA Vic).

34 *R v Neal* (1982) 149 CLR 305, Brennan J at 324.

35 (1980) 31 ALR 257, 305-11. See also *McDermott v R* (1948) 76 CLR 501, 512.

36 Many of the dangers and undue influences which must be addressed are discussed in the next section which deals with the possible bad consequences flowing from euthanasia.

37 See *R v Day* (1841) 9 C & P 724, where submission and consent were distinguished.

(ii) The Argument that Euthanasia is Voluntary: Therefore Those Who Do Not Want it Need Not Take it up

In a bid to buttress the autonomy argument, euthanasists have contended that given the pluralistic nature of Australian society and the different moral perspectives which exist in it, individual autonomy should prevail and hence euthanasia should be permissible for those who want to avail themselves of it. Those who find euthanasia morally wrong, supposedly, have their views respected by not being required to take up the option should it become relevant.[38]

This argument fails for two reasons. It adopts a subjective view of morality, which followed to its logical conclusion entails that all types of clearly reprehensible activities are justified and beyond moral censor. For example, the argument implies that activities such as slavery are also justified so long as a person elects to be a slave. This is clearly wrong, for morality is not a matter of taste or personal preference. And theories based on such assumptions, such as cultural relativism[39] and subjectivism,[40] have been discredited long ago. If an activity is objectively morally wrong consent is beside the point. The fact that an activity involves the free involvement of a person is one of many considerations relevant to its moral appraisal. If despite the presence

38 For example, H Kuhse in her oral submission to the Northern Territory Select Committee on Euthanasia, stated 'to kill a patient by administering a lethal therapeutic drug, is wrong. To bring about the same consequence ... by turning off the life support is not wrong... I do not share this belief, but there are many in society who hold this belief. In the end one cannot argue about it, because these views are based on deep philosophical value judgements (*Report by The Northern Territory Select Committee on Euthanasia*, vol 1, at p 11). See also, Kuhse and Singer, note 23 above, p 131.

39 Cultural relativism is the theory that there are no universal or objective moral standards. It maintains that the rightness of an act is context sensitive: according to the values of the society in question. What is right or good is that which accords with the moral code of the society under consideration. Cultural relativism has been described as 'the anthropologist's heresy, [and] possibly the most absurd view to have been advanced even in moral philosophy' (B Williams, *Morality: An Introduction to Ethics* (Penguin, 1971), p 34). It is incoherent because it advocates a non-relative virtue of tolerance. On the one hand it provides that morality is always *relative* to the standards of the culture in question, but then says it is *always* wrong (in a non-relative sense) to criticise or pass judgement on another society's values.

40 Subjectivism is the view that when a person says something is morally good or bad this merely means that he or she approves or disapproves of the thing. It is subject to many of the same criticisms as relativism, and further has been rejected because it implies we can never be wrong with our moral judgements. Also it cannot account for disagreement in ethics and leads to self-contradiction (see J Rachels, *The Elements of Moral Philosophy* (McGraw-Hill Publishing Company, 1986), pp 26-30).

of consent or autonomy a practice is nevertheless judged morally wrong, consent or autonomy cannot then again be applied to trump the initial moral evaluation. One cannot double dip and exploit the virtue of autonomy to override 'the umpires decision'. The other counter available to opponents of euthanasia is that due to the bad consequences associated with euthanasia, once legalised it will not be voluntary for very long. I now turn to this issue and other possible problems associated with decriminalising euthanasia.

3. Possible Detriment to the Public Good Due to Decriminalising Euthanasia

(i) Voluntary Euthanasia Will Lead to Involuntary Euthanasia

Many of the possible bad consequences accompanying euthanasia are embodied in the slippery slope, or the dangerous precedent, argument. This argument is often invoked in relation to acts which in themselves are justified, but which have similarities with objectionable practices, and urges that in morally appraising an action we must not only consider its intrinsic features but also the likelihood of it being used as a basis for condoning similar, but in fact relevantly different undesirable practices.

The slippery slope argument has been criticised on the basis that it logically prevents change and advancement: the slippery slope argument amounts to the principle 'that you should not now do an admittedly right action for fear that you ... should not have the courage do to the right thing in some future case, which ex hypothesi is essentially different, but superficially resembles the present one. Every public action which is not customary, either is wrong, or, if it is right, is a dangerous precedent. It follows that nothing should ever be done for the first time.'[41]

This however fails to recognise the real force behind the slippery slope argument, which lies in our propensity to justify 'progress' by analogising from one situation to another, and our fallibility in discerning the relevant and significant factors about the practices we are comparing.

Accordingly, an important feature in assessing the strength of the slippery slope argument in the case of euthanasia is whether the reasons advanced in favour of euthanasia are so overtly obvious and pe-

[41] F M Cornford, *The Microcosmographia Academica* (Cambridge University Press, 1908) p 23.

culiar to it that there is little prospect of them being misinterpreted and used to 'justify' other ostensibly similar, but immoral activities.

Logical Version of Slippery Slope Argument

In its logical form, the slippery slope argument is unconvincing. The reasons advanced in favour of euthanasia, such as the avoidance of unnecessary pain and respect for liberty, do not logically justify other killings.[42] In theory, these constitute clear and rational grounds that can be used to distinguishing between euthanasia and other forms of killing.

Empirical Version of Slippery Slope Argument

The empirical version of the argument provides that if euthanasia is permitted, as a matter of fact, involuntary euthanasia and other immoral activities are but a short inevitable step away: once patient's are assisted to die, they will then be covertly encouraged to die, then pressured to die. The slippery slope process is already well advanced in the case of active euthanasia. From the fact that suicide is not illegal it has been argued that assisted suicide is therefore permissible, hence so too should be passive euthanasia, and given that this is widely practised we should likewise sanction active voluntary euthanasia, because if we are going to stand by as the person dies anyway, surely we should hasten this to make the process as painless as possible. The issue then becomes whether this progression can be halted at active euthanasia. In order to assess the empirical version of the slippery slope argument, it is necessary to consider the developments in societies where it has been practiced.

In this regard, the first place that many opponents of euthanasia commonly turn to is Nazi Germany. It is then suggested that this experience shows that active euthanasia may lead to the type of barbaric activities which occurred there, such as killing people in mental hospitals. However, the Nazi extermination policy did not grow from voluntary euthanasia, and it is hard to see why a policy motivated by a desire to relieve pain and respect for liberty should have such abhorrent side-effects.[43] The Nazi experience was not caused by a slide

[42] H Kuhse, 'Euthanasia' in P Singer (ed), *A Companion to Ethics* (Blackwell, 1991) pp 294, 301.

[43] Glover, note 8 above, p 186. Although see B Pollard, *The Challenge of Euthanasia* (The Mount Series, 1994) p 57 who states that the euthanasia program in Nazi Germany was initially motivated by compassion, inadequate quality of life and cost containment, and Rachels, note 9 above, pp 176-8, where he cites historical analysis that such programmes were started with a small shift in emphasis in the

down any slippery slope, rather by the racist and elitist ideology which was entrenched from the start,[44] hence is of no significance to this discussion. The best evidence of the where euthanasia will lead us to is the Netherlands, the only location where it is openly practiced.[45]

The Practice and Evidence From the Netherlands

The empirical evidence from the Netherlands appears to be quite disturbing. In 1991 a government committee, headed by P J van der Mass,[46] reported that in 1990 there were 2,300 cases of voluntary euthanasia, 400 cases of assisted suicide, and 1,000 cases of involuntary euthanasia. Additionally there was a further 23,350 cases in which doctors, by act or omission, intended to shorten life,[47] and according to the definitions adopted earlier 6,858 of these cases constituted euthanasia.[48] Thus the total number of cases where the doctor's

basic attitude of physicians. This is a view shared by M D Kirby, in 'The Rights of the Living and of the Dying' (1980) 1 *Medical Journal of Australia* 252.

44 Rachels, note 9 above, p 178, where he outlines the views reached by the historian of the Nazi era, Lucy Dawidowicz.

45 Euthanasia is strictly still illegal in the Netherlands (the Dutch Penal Code, Article 293, provides that intentional killing of a person at his or her 'express and serious' request is an offence). However the courts have ruled that a doctor who participates in euthanasia, or assisted suicide, can successfully claim the defence of necessity if appropriate guidelines are followed. The understanding and practice over the past 20 years or so is that there will be no prosecution where there has been adherence to the guidelines. These include that: all other treatment options have been considered and found wanting; the patient's request to die is free, well-informed and durable; the patient must be experiencing intolerable (not necessarily physical) suffering with no prospect of improvement; and the doctor who is to perform euthanasia must consult with an independent doctor who has experience in the field. For a thorough account of the legal status and treatment of euthanasia in the Netherlands, see J Keown, 'Some Reflections on Euthanasia in the Netherlands' in L Gormally (ed), *The Dependent Elderly, Autonomy, Justice and Quality of Care* (Cambridge University Press, 1992), p 70; and J K Mason and R A McCall Smith, *Law and Medical Ethics* (Butterworths, 1994) ch.15; Otlowski, note 3 above, pp 391-455.

46 P J van der Mass et al, *Euthanasia and other Medical Decisions Concerning the End of Life* (Elsevier, 1992) ('the van der Mass survey'). For a summary of these findings see J Keown, note 45 above and 'Further reflections on Euthanasia in the Netherlands in the Light of the Remmelink Report and The van der Mass Survey', in L Gormally (ed), *Euthanasia, Clinical Practice and The Law* (Linacre Centre, 1994), pp 193, 219.

47 These are comprised as follows: 16,850 cases where the doctor's explicit or partial purpose was to shorten life by either administering palliative drugs (8,100 - explicit 1,350; partial 6,750) or by withholding or withdrawing treatment without request (8,750 - explicit 4,000; partial 4,750); and 5,800 cases of withholding treatment on request with the partial or explicit purpose of shortening life (explicit 1,508; partial 4,292).

48 1,350 plus 4,000 plus 1,508.

primary intention was to shorten life was 10,558.[49] Notably in 5,450 of these cases (or 52%) the patient had not expressly requested to die.[50]

Perhaps the most telling finding of the survey is the 1,000 cases of involuntary euthanasia. This translated to 27% of doctors admitting to terminating lives without request,[51] and clearly shows that voluntary euthanasia has led to widespread involuntary euthanasia. It has been suggested that these finding are somewhat ameliorated by the fact that 'in more half of [the 1,000 instances of involuntary euthanasia], this *possibility* had already been *discussed* with the patient, or the patient had expressed, in a *previous phase* of the disease a wish for *active voluntary euthanasia*, if his or her suffering became unbearable (emphasis added)'.[52] However, this is little cause for comfort. Merely canvassing a certain option with another party, does not approach anything even resembling consent to that course of conduct. And the suggestion that a wish for voluntary euthanasia makes involuntary euthanasia in some way more acceptable merely confirms the force of the slippery slope argument.

The attitude of the people of the Netherlands also supports the slippery slope argument. In 1986 the results of a poll indicated that 77% of the population supported involuntary euthanasia. Ninety per cent of economics students felt that euthanasia should be compulsory for certain groups. This is in stark contrast to those in nursing homes where 93% opposed euthanasia.[53]

Overall, the survey supports the contention that the practice of euthanasia has not resulted in greater patient autonomy, but in doctors 'acquiring even more power over the life and death of their patients',[54] and that within a relatively short period of time the Dutch have proceeded down the slippery slope from voluntary to involuntary euthanasia. 'This is partly because the underlying justification for euthanasia is not ... self-determination, but rather acceptance of the

[49] 6,858 plus 2,300 (voluntary euthanasia as defined in the survey) plus 1,000 (involuntary euthanasia). Considering that the total number of deaths in that year in the Netherlands was about 130,000 this represents about 8% of the total deaths.

[50] Keown, note 46 above, pp 219,232.

[51] J Keown, 'The Law and Practice of Euthanasia in the Netherlands' (1992) 108 *LQR* 51.

[52] Otlowski, note 3 above, pp 430-1.

[53] Lanham, note 20 above, p 170.

[54] A M J Henk and V M Velie, 'Euthanasia: Normal Medical Practice?' (1992) 22(2) *Hastings Centre Report* 34, 38.

principle that certain lives are not worth living and that it is right to terminate them'.[55]

A follow up study in the Netherlands in 1995, revealed similar results to those some four years earlier. There was a slight increase in the percentage of overall deaths stemming from active euthanasia (2.4%, compared to 1.7% in 1991), but a slight decrease in number of cases of involuntary euthanasia: from 1,000 to 900 in 1995.[56] These results are somewhat equivocal in terms of establishing a general trend.[57] Given the small drop in the number of cases of involuntary euthanasia it could be argued that this throws doubt on the slippery slope argument.[58] This can be countered on the basis that the decrease in the incidence of involuntary euthanasia (10%) over the four year period is not statistically significant and that the period of time between the surveys was insufficient for the cultural and attitudinal changes which it is feared will result in the advent of the slippery slope dangers to develop. Given the relatively short period of time between the two studies and the close correlation of the relevant data, perhaps the most telling result from the 1995 study is that it confirms the accuracy of the previous survey.

The Relevance of the 1991 Survey

The significance of the 1991 Dutch survey has been questioned. The valid point has been made that in order to obtain meaningful information regarding the slippery slope dangers it is necessary to compare the level of abuse before and after voluntary euthanasia was introduced.[59] For this reason it can be argued that a final verdict has not been reached. But this should not prevent one forming a prima facie view. The evidence, the *only* cogent evidence, shows that in a climate where voluntary euthanasia is openly practiced, there are also a large number of cases of involuntary euthanasia. It may be that the rate of involuntary euthanasia in the Netherlands was not increased by the decision to effectively give the green light to voluntary eutha-

55 Keown, note 46 above, pp 219, 239.

56 The results of the 1995 study are summarised in the Report of the Senate Legal and Constitutional Legislation Committee, The Parliament of Australia, *Euthanasia Laws Bill 1996*, (Canberra, 1997) 101-6.

57 Not surprisingly both sides of the debate have attempted to skew these results to their advantage: see Report of the Senate Legal and Constitutional Legislation Committee, Parliament of Australia, *Euthanasia Laws Bill 1996* (Canberra, 1997), 101-5.

58 For example, see M Angell, 'Euthanasia in the Netherlands – Good or Bad?' 335(22) *The New England Journal of Medicine*, 1676.

59 For example, see Otlowski, note 3 above, p 439.

nasia. But given that we know that one state of affairs (ie where euthanasia is openly practised) *definitely* leads to undesirable consequences and are unsure about the situation in the alternative state of affairs (where euthanasia is prohibited), logically we ought to opt for the later - speculative or possible dangers being accorded far less weight than certain ones.

Overall, the significance and poignancy the slippery slope argument is aptly summarised by the House of Lords Select Committee on Medical Ethics: 'issues of life and death do not lend themselves to clear definition, and without that it would be impossible to ensure that it would be possible to frame adequate safeguards against non-voluntary euthanasia were voluntary euthanasia to be legalised. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that liberalisation of the law was not abused'.[60]

Other Slippery Slope Consequences – Loss of Respect for Life

Every society has some prohibition against taking life,[61] and 'the intentional taking of human life is ... the offence which society condemns most strongly.'[62] If the stringency of this prohibition is relaxed, by permitting euthanasia, there is the risk that it may result in a diminution in the importance accorded to the right to life across the board. Thus legalising euthanasia not only risks leading to involuntary euthanasia; but also to killing in other circumstances, or at least to a reduction in the endeavours taken to protect and save life.

James Rachels argues that there is no truth in the argument that once life in one circumstance is cheapened that the currency tends to drop all round. In support he cites the examples of the Eskimos, who used to sacrifice infants and the feeble as a measure to ward of starvation, and the acceptance of killing in self defence.[63]

However these examples are not on point. The Eskimo and self-defence cases both involve a conflict of the right to life. Due to the extreme circumstances in which such clashes arises, it is perceived, a choice *must* be made between one life and that of another of others. Unlike with euthanasia, the reason for killing in these cases is due to

60 Report of the House of Lords Select Committee on Medical Ethics, p 49.

61 P Singer, *Practical Ethics* (Cambridge University Press, 1993, 2nd ed.) p 85.

62 House of Lords Report of the Select Committee on Medical Ethics vol 1, p 13.

63 Rachels, note 9 above, p 1974. He also cites the example of the ancient Greeks who used to kill defective infants. However, he does not state why they used to engage in this practice, and hence I am unable to comment on the strength of this particular analogy.

the absolute *necessity* to preserve the lives of others. This does not lead to a devaluation in the respect for life because the killing is in fact motivated by the desire to save life. The Eskimos kill as a last resort to save what they deem as more important lives. We kill in self-defence out of desperation, recognising that when one life must be lost it should be that of the person who has wrongly created the desperate situation. There is no inherent devaluing of the life to be lost, merely an illustration of the fact that at times monumental choices are unfortunately cast upon us. Not so with euthanasia. There is no necessity to offset one life against the other. With euthanasia the decision to kill is far more calculated. It requires one to arrive at the *considered* conclusion, which albeit may not be the decisive motivation for the act, that a particular human life is not worth continuing or can be sacrificed to satisfy some other interest. Not because it means therefore another life will be lost, but rather to pursue some other interest than the right to life itself. This attitude departs radically from the regard currently paid to the importance of life whereby it is not subordinate to any other goal or interest.

Thus history provides no comfort for the view that if we allow killing in the context of euthanasia that this will not lead to a devaluation of life generally and a lessening in the aversion to killing in other contexts. While it is difficult to obtain empirical evidence supporting the fact that it does,[64] once again, given the importance of what is at stake the onus is on those advocating a change to produce cogent evidence or reasons why such a danger is unlikely to eventuate.

(ii) Risk of Abuse and Manipulation of the Patient

Terminally ill patients are typically at the lowest psychological point in their lives, and are particularly susceptible to manipulation and abuse by relatives, who may either intentionally wish harm upon them, or merely wish to end a very difficult time for all, or lead them, even inadvertently, to believe that their lives are not worth living.[65] If patients 'were to perceive that doctors were ready to kill where they

64 The immense civilian atrocities that have occurred during and immediately following wars provide some evidence of this, but given the large number of variables involved during such climactic periods it is impossible to positively isolate the cause for such disasters.

65 P K Longmore, 'Elizabeth Bouvia, Assisted Suicide and Social Pressure' (1987) 3 *Issues in Law and Medicine* 141, where it is argued that there are pressures on the weakest and most vulnerable members of the community which lead to such a belief.

could not cure'[66] not only would this damage the doctor-patient relationship,[67] but it may also result in added pressure on the patient by creating a climate in which some patients are perceived 'as lingering nuisances whose worth and well being are no longer significant'.[68] 'The evidence from the Netherlands is that an option can become an expectation, and an expectation can become an obligation'.[69] While in only 2% of instances was 'no longer wanting to be a burden' advanced as the main reason for a request to die, in almost a quarter of the cases (22%) this was an influential reason.[70] This coupled with the privacy in which such a decision is made and the position of weakness of the patient present insurmountable obstacles to framing legislation which can adequately safeguard against abuse.[71]

66 British Medical Association, *Euthanasia, Report of the Working Party to Review the British Medical Association's Guidance on Euthanasia*, May 1988, para 238.

67 The possible damage to the doctor and patient relationship which may occur if euthanasia is legalised is regarded by some as being in itself a powerful argument against euthanasia. For example, it has been stated that if doctors were authorised to give lethal injections some groups, such as aborigines, may be more reluctant to seek routine health care (*Report by the Northern Territory Select Committee on Euthanasia* (1995) 12-15). Similarly, the submission by the British Medical Association to the House of Lords Select Committee on Medical Ethics at vol II 26, 29, provides that 'if doctors are authorised to kill or help kill, however carefully circumscribed the situation, they acquire an additional role, alien to the traditional one of healer... As a result some may come to fear the doctor's visit'.

68 Pollard, note 43 above, p 121.

69 Pollard, note 43 above, p 121. See also, B A Bostrom, 'Euthanasia in the Netherlands: A Model For the United States' (1989) 4 *Issues in Law and Medicine* 467, 477.

70 Pain and suffering was mentioned as the most important reason for the request in 59% of cases, while in another 24% of cases it was fear of or the avoidance of humiliation (*Report by the Northern Territory Select Committee on Euthanasia 1995*, p 36, which cites G van der Wal, et al 'Euthanasia and Assisted Suicide: Do Dutch Family Doctors Act Prudently?' *Family Practice* 1992b, vol.9 no 2, 135-140).

71 Five comprehensive inquiries which have been conducted to inquire into the consequences of decriminalising euthanasia have all concluded that it should not be legalised due to unacceptable detrimental consequences which would ensue. These inquires were: Law Reform Commission of Canada, *Euthanasia, Assisting Suicide and the Cessation of Treatment* (1982); Social Development Committee of the Parliament of Victoria, *Inquiry Into the Options for Dying With Dignity* (1987); House of Lords Select Committee on Medical Ethics (1994); New York Task Force on Life and the Law, *When Death is Sought* (1994); and Special Committee on Assisted Suicide and Euthanasia of the Senate of Canada, *Of Life and Death* (1995). The attitude of the House of Lords Select Committee on Medical Ethics, at 49, is typical of some of the dangers which were adverted to. Concerned that vulnerable people may feel pressure to request an early death if euthanasia was legalised, it stated that 'the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life'. A referendum in Washington in 1991 to legalise active euthanasia and assisted suicide was defeated,

Against this, it is claimed that in an unregulated environment where there are no safeguards the potential for abuse is much higher. Doctors already make life and death decisions without legal or publicly debated safeguards,[72] and it is only if euthanasia was permitted that guidelines and standards could be established to minimise the scope and likelihood of abuse.[73]

However legalising and regulating an activity which seems difficult to completely stop is not always an appropriate response. Otherwise an argument could be made for legalising shop lifting; but only for amounts less than ten dollars. Harm minimisation is only appropriate for activities which are not inherently wrong and it is accepted are effectively unstoppable (due to their intense temptation for some) such as gambling and prostitution and to a lesser degree under age sex and intravenous drug taking.[74] But as with other types of murder, neither of these pre-conditions exists in relation to euthanasia. Thus evidence of large scale abuse by medical professionals supports the need for the more vigilant enforcement of the criminal law, as opposed to a relaxation of it.

55% to 45%, primarily due to the perceived lack of adequate safeguards. The Canadian Supreme Court in *Rodriguez v A-G British Columbia* [1993] 3 CSCR 519 considered the limits of the right of personal autonomy in relation to assisted suicide and along similar lines to the conclusions adopted in the above reports held that personal liberty did not prevail over the proscription against assisted suicide which protected the terminally ill who were particularly vulnerable. Only the Report by the Northern Territory Select Committee on Euthanasia failed to be decisively swayed by the dangers of legalising euthanasia.

72 A survey of medical professionals in South Australia showed that 19% of doctors had taken active steps to end the lives of patients, while another study showed that 40% of doctors had received requests to hasten a terminally ill patient's death, and of these 29% said that they responded to the request (H Kuhse and P Singer, 'Doctors Practices and Attitudes Regarding Voluntary Euthanasia' (1988) 148 *Medical Journal of Australia*, 623). See also, C Stevens and R Hassan, 'Management of Death, Dying and Euthanasia: Attitudes and Practices of Medical Practitioners in South Australia' (1994) 20 *Journal of Medical Ethics* 41. The results of a postal survey in 1996 suggested that about 35% of all Australian deaths involve a medical decision either partly or explicitly to hasten death or end life, and that Australia had a higher rate of intentional ending of life without the patient's request than the Netherlands (H Kuhse and P Singer, et al, 'End-of-life Decisions in Australian Medical Practice' (1997) 166 *Medical Journal of Australia* 191). The methodology of this survey has been criticised for failing to conduct interviews with the respondents (as was the case with the Dutch survey) and for the imprecision of the terms used in the survey, such as grouping 'hastening death' with 'not prolonging life'.

73 T Cipriani, 'Give Me Liberty and Give Me Death' (1995) 3 *JLM* 177, 186.

74 The availability of contraception to minors, at schools and the like, and syringes to drug users reflects the efforts to minimise the harm from under age sex and drug taking.

In light of the above, the argument that decriminalising euthanasia will secure patient autonomy is short-sighted. While decriminalisation may secure the autonomy of the small number of clear minded patients seeking death,[75] it poses a serious threat to the autonomy of the large number of overall euthanasia candidates who resent being forced to make such a 'choice'. A counter by euthanasists that the possible unsavoury side-effects of euthanasia can be tackled by appropriate safeguards would come at too high a price and only serves to highlight the paradox they find themselves in. Increasing safeguards would invariably encroach on patient autonomy by restricting patient choice, on such integral matters as the timing and type of death, and accordingly the cornerstone of their whole thesis would be in danger of self-collapsing.

(iii) Pressure on the Health System to Reduce Palliative Care Funds

Human suffering is as tortuous to witness as to endure. Vast resources are devoted to palliative care as this is the *only* means to alleviate pain in the terminally ill. The decriminalisation of euthanasia would provide an alternative means of pain relief and hence a dwindling in the urgency to relieve pain through palliative care. The desire to develop better terminal care or to maintain the current funding for such care[76] would be weakened, if not annulled, and there would be great pressure on the already stretched health budget to redirect funds away from palliative care.

An argument can be made that this is not undesirable. We should try to get the maximum value for our health dollar and it is an incorrect allocation of health resources to direct so much to those who will shortly die anyway - on a cost/benefit analysis of human economy it is far better to prioritise the interests of patients who can be cured.[77]

75 Only a small minority of terminally ill patients request to die and only about 0.1-0.2% of cancer patients commit suicide (D Cundiff, *Euthanasia is Not the Answer* (Humana Press; New Jersey, 1992) 7-8). See also Hunt et al, 'The Incidence of Requests for a Quicker Terminal Course' (1995) 9 *Palliative Medicine* 167 where it is reported that in a palliative care unit in Adelaide only 6% of patients expressed a wish for assistance to die when asked the question.

76 It has been suggested that if euthanasia had been permissible earlier, the hospices movement might not have developed, see S G Potts, 'Looking for the Exit Door: Killing and Caring in Modern Medicine' (1988) 25 *Houston LR* 493, 507.

77 For example, P Singer in his submission to the Victorian Social Development Committee (above n 71, at p 86), stated 'it would be absurd to suggest that... we should always do everything possible to prolong life, irrespective of the wishes of the patient ... or of the patient's prospects of leading a life which anyone would consider worthwhile. Quite apart from the cruelty and denial of autonomy which

However, even if one ignores the objection that it is odious to think of human life purely in dollar terms, a preference for the terminally ill in the battle for the health dollar can be asserted on the grounds that not only are they the most needy, but also the price for ignoring them is too high. Less resources to palliative care means more patients dying in pain, and this constitutes a repudiation of one of the most fundamental priorities of any civilised health system - the immediate relief of pain. The quantity of pain relieved through acceding to the dying wishes of a few[78] is outweighed by the suffering which will be endured by the sizeable majority of the terminally ill who do not want euthanasia but are denied access to appropriate palliative care. Failing to fund treatment for the terminally ill will also result in pressures to go beyond voluntary euthanasia:[79] 'as the health budget becomes increasingly stretched killing instead of caring for those who are about to shortly die anyway ... [killing] may become an increasing attractive option, and this would be even more so if euthanasia was permissible'[80].

4. Conclusion

The extent to which euthanasia will actually advance patient autonomy has been over-stated. Due to the vulnerability of the patient it is almost impossible to ascertain the level of freedom and rationality associated with a decision to die. Even in the unlikely scenario that some degree of meaningful true autonomy could be guaranteed the probable adverse consequences accompanying the practice are so se-

such a course would involve, the burden on our already strained health care resources would require substantial cuts in other areas which would be very difficult to defend'. The problem is only likely to increase in the future as the number of hopelessly ill patients continues to increase with developments in medical technology and it may soon be beyond society's resources to prolong such meaningless lives (A Browne 'Assisted Suicide and Active Voluntary Euthanasia' (1989) 2(1) *Cdn J of Law & Juris* 9, 12). But cf E J Emanuel and L L Emanuel, 'The Economics of Dying: The Illusion of Cost Savings at the End of Life' (1994) *The New England Journal of Medicine* 540.

78 See note 75 above.

79 It is cheaper to end the life of a terminally ill patient than to provide adequate medical and palliative care (D Mendelson, 'The Northern Territory's Legislation in Historical Perspective' (1995) 3 *JLM* 136, 141). The House of Lords Select Committee on Medical Ethics stated that 'despite the continuing inevitable constraints on the health-care resources the rejection of euthanasia ... entails a compelling social responsibility to care adequately for those who are elderly, dying or disabled. Such a responsibility is costly to discharge, but it is one which we cannot afford to neglect (*Report of the House of Lords Select Committee on Medical Ethics*, vol I, p 57).

80 Potts, note 76 above, pp 493, 507.

rious that a decision to nevertheless decriminalise euthanasia would be misguided and irresponsible.

Morality provides, and the law has accepted, that while autonomy and consent are desirable virtues they are not absolute and must yield where the activity in question would be contrary to the common good. For example, one cannot generally consent to bodily injury beyond a certain level[81] due to the importance the courts place on physical integrity and the unsavoury social consequences which would ensue were such behaviour condoned.[82] It logically follows that total self-destruction cannot be totally or even significantly justified on the basis of a concept which cannot even justify less harmful behaviour.

Perhaps adequate safeguards could be implemented to prevent voluntary euthanasia leading to involuntary euthanasia and maybe we can be adequately conditioned into accepting that deliberate killing in one context, does not diminish the value of all human life. But until compelling evidence and strong arguments are advanced to these ends, there is no justification for a change in the law regarding euthanasia - there is too much to lose.

81 One cannot consent to injury unless there is good reason to justify the relevant behaviour. Good reason includes surgery and sporting activity and socially acceptable self-decoration, such as tattooing and ear-piercing; however not sadomasochism (*R v Brown* [1994] 1 AC 212).

82 See, *R v Coney* (1882) 8 QBD 534 which discusses the adverse consequences associated with prize fighting.