STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

(Legislation and References)

Inquiry into End of Life Choices

Submission on behalf of the Social Responsibilities Committee of the Anglican Diocese of Melbourne, prepared by Dr. Denise Cooper.

Executive Summary

- The distinction drawn by medicine and the law between euthanasia and 'letting die' by withdrawal or withholding of treatment, even in the case of life prolonging treatments, should be maintained.
- Advance Care Planning should place less emphasis on rigidly enforceable Advance Care Directives and adopt a broader approach that emphasises the careful appointment of a medical substitute decision maker and that encourages the patient to identify and discuss their values and beliefs with that decision maker, family, friends, and their health care team.
- Victorian law should clarify that doctors may use medically accepted, appropriate and effective pain relief at the end of life without fearing prosecution, if their intention is clearly to relieve pain and not to end life. All medical practitioners should be adequately trained in the administration of pain relief at the end of life.
- Patients should not be forced, by inadequate palliative care, into seeking death as an escape from treatable pain and other suffering. End of life care, education and research require additional funding so that people do not die badly due to lack of palliative services.
- Euthanasia and physician assisted suicide (PAS) should remain legally prohibited. Respect for human life is not just a religious value, but a foundational value of all societies in which reasonable people would want to live. The life of each individual has an equal claim to respect, because the value and dignity of each person is not diminished by age, disease, dependence or disability. The two major arguments for permitting euthanasia, used separately or together, are the argument from the principle of respect for patient autonomy and the argument based on the obligation to relieve suffering where possible. Both arguments are flawed.
- Euthanasia cannot and will not be limited to competent patients or to the terminally ill, or even the physically ill. The moral logic of the two justifications for euthanasia demands the extension of the practice both beyond those who are able to decide for themselves and beyond those who are suffering. The extension of both practices is seen clearly in the changes to the law and practice in jurisdictions where euthanasia and PAS have already been legalised.
- The euphemism 'assisted dying' aims to mask the fact that euthanasia and PAS are actually forms of suicide. Legalising euthanasia and PAS will send mixed messages about suicide prevention. To approve suicide for some but not others is inherently discriminatory, and indicates that some lives are considered of more value than others.

In 2010, The Synod of the Anglican Diocese of Melbourne passed the following motion:

That this Synod reaffirms the resolution of the General Synod of Australia (1995) concerning Euthanasia, namely:

- We affirm that life is a gift from God not to be taken, and is therefore not subject to matters such as freedom of individual choice.
- We cast doubt on whether a practice of voluntary euthanasia can be prevented from sliding into a practice of involuntary euthanasia.
- We affirm the right of patients to decline treatment but not to expect the active intervention by medical staff to end their lives.

And calls upon

1. Members of the Victorian State legislature to vote against legislation to legalise euthanasia when such matters come before our Parliament; and
2. Governments to further improve access to high quality palliative care to ensure that all people will be able to die with dignity.

WITHHOLDING OR WITHDRAWAL OF MEDICAL TREATMENT

The Victorian *Medical Treatment Act* 1998 protects a competent patient's right to refuse unwanted medical treatment, including potentially lifesaving or life prolonging treatment. In addition, doctors may withhold or withdraw treatment that is futile or unnecessarily burdensome. Such situations may be described as permissible 'letting die'. The medical profession and the law maintain a clear distinction between 'letting die' in such situations and killing a patient, for example by lethal injection (active euthanasia). Statements of medical associations worldwide affirm the distinction (American Medical Association 1994, Australian Medical Association 1997, British Medical Association 2000, Canadian Medical Association 1998, World Medical Association 2002). In law, a person may be guilty of killing (homicide) by means of an omission or failure to act as well as by an act. However, an omission that results in death is not killing in a legal sense unless there is a duty to act. In the medical context, there is no duty to provide treatment that is deemed futile or excessively burdensome.

A number of landmark international cases have clarified that even life prolonging treatments such as the provision of artificial ventilation or artificial nutrition and hydration (ANH, also sometimes called tube feeding) to seriously brain damaged individuals may be discontinued at the request of family members. In Victoria, the judgment in *Gardner; re BWV [2003] VSC 173* gave permission for the Public Advocate guardian of a patient with advanced dementia to refuse ANH on her behalf.

Although some argue that nutrition and hydration are basic to human life and should never be withdrawn, when they are provided by means of a surgically inserted percutaneous endoscopic gastrostomy (PEG) tube, they may plausibly be seen as medical treatment, which may be refused by a patient or by their substitute decision maker. The intention in removing ANH may be seen as not to kill, but to recognize the limits of life. According to this view, when medical treatment can offer no hope of pursuing the spiritual goods of life, as for example when a patient is in a persistent vegetative state, there is no duty to preserve life and the patient should be allowed to die. It is important to note, however, that disagreements as to whether particular treatments ought to be continued under certain circumstances are not disagreements about the legitimacy of medical killing. They are disagreements about what is permissible medical 'letting die'.

In the Christian tradition, maintaining the distinction between killing and 'letting die' has to do with the virtue of humility. It is to understand that life is a gift from God,

which we cannot take from another person, nor even from ourselves. To give the medical profession the power and authority to determine when someone will die is to usurp God's authority- to 'play God' as is sometimes said- and to demonstrate the vice of hubris or unbridled arrogance. When a decision is made to withhold or withdraw medical treatment, it is often described as allowing nature to take its course, but it is really an admission that we've reached the end of our power to keep this person alive. We don't know what will happen, but we stop interfering and leave the person (it may be ourselves) in God's hands. Medicine is generally about healing, resisting disease and death, and this is godly work, because God is on the side of healing and wholeness, and death is an enemy. At the same time, at some point for all of us, death must be accepted. It is the necessary pathway to resurrection and new life. To be human is to be mortal, and so the time does come to stop fighting death. Death is an enemy that need not always be resisted, but we should never collaborate with it. Knowing when this time has come for each of use calls for wisdom and discernment.

It may be particularly difficult for doctors to discern that the time has come to let someone die, because of the power of modern medicine to 'keep people alive'. The death of a patient may be seen as a failure. But it has not always been so in medicine. The Hippocratic work *The Art* defines the goals of medicine as 'to do away with the sufferings of the sick, to lessen the violence of their diseases, and to refuse to treat those who are overmastered by their diseases, realising that in such cases medicine is powerless'. (The Hippocratic tradition, as expressed in the Hippocratic *Oath*, also prohibited physician-assisted suicide, thus maintaining the moral distinction between killing and 'letting die').

In summary, medical opinion and the law continue to draw a distinction between killing and 'letting die' by treatment abatement, even in the case of life prolonging treatments such as renal dialysis, artificial ventilation and tube feeding. We believe that this distinction should be maintained, and that while neither euthanasia (nor physician assisted suicide) is morally permissible, 'letting die' is not only permissible in certain circumstances, but also sometimes morally required.

ADVANCE CARE PLANNING

In 2012, the Synod of the Anglican Diocese of Melbourne commended Advance Care Planning as a process to help people make decisions about their future medical care in order to honour the rights, values and beliefs of individuals and to relieve their families of later anguish related to uncertainty about these. Parishes, chaplains and church agencies were urged to raise awareness of this process and encourage its use.

The mover, Morwen Watkins, noted that up to seventy per cent of patients are incapable of making important end of life decisions when the time comes. This can lead to suffering and indignity, when the dying process is prolonged, perhaps with invasive treatments that the person would not have wanted.

The Victorian *Medical Treatment Act* 1998 provides for a competent person to write a refusal of treatment certificate (RTC). This formalised what was already the case in common law, that doctors could not treat competent patients without their consent. (Although for the purposes of this Act, 'medical treatment' does not include 'palliative care'). An RTC however, only covers treatment for an existing medical condition.

Understandably, some patients may wish to record in advance their decisions to refuse or consent to treatment for future conditions, which might arise when they are not competent to decide. For example, if a person has dementia, would they want chemotherapy if they developed cancer, or antibiotics for an infection, or renal dialysis

or cardiopulmonary resuscitation? Of course, in many of these cases, such treatments might not be offered by the treating medical team, but sometimes they would be and these treatment preferences can be recorded in a non-legislated Advance Care Plan. A non-legislated Advance Care Plan (ACP) is a document, which is created by a person while they are competent, that provides for a person to define the medical treatment they wish in defined circumstances should they lose medical decision-making competence. But the document need not be so prescriptive or so specific. It might simply record the patient's values, beliefs and understanding of 'quality of life'; information that they would want taken into account by others who need to make medical decisions on their behalf.[1]

Writing an ACP (a legislated RTC or a non-legislated document) is only one element of Advance Care Planning. It may also include reflection and discussion with friends and family about one's beliefs, values, goals in life and preferences regarding medical treatment; letting family and friends know about one's preferences and what has been specified in an ACP and discussion with one's GP and other health professionals about future possibilities in terms of illness. Many regard these discussions as the most significant aspect of Advance Care Planning. Hence the title of the Victorian Department of Health's Advance Care Planning strategy: 'Have the Conversation'.[2]

Another very important component of Advance Care Planning is the appointment (where possible) of an agent to make medical decisions on one's behalf. The *Medical Treatment Act* already provides for a competent person to appoint an agent to consent to or refuse medical treatments, including potentially lifesaving or life prolonging treatments, on their behalf, in the event that they are unable to make these decisions for themselves at some time in the future. However, an agent appointed as Enduring Power of Attorney (medical treatment) may only refuse medical treatment on behalf of a patient if the treatment would cause unreasonable distress to the patient, OR there are reasonable grounds for believing that the patient, if competent, and after giving serious consideration to his or her wellbeing, would consider that the medical treatment is unwarranted.

In allowing for greater patient autonomy, ACPs are an important symbol of medicine's (relatively recent) commitment to patient empowerment and the valuing of patients as partners in decision-making.[3] They also encourage people to face and plan for what most of us would rather ignore - our own death and dying. 'People often resist thinking about death. However… systematic advance care planning acts as a concrete aid for prodding people to overcome their aversions and face the hard decisions about dying'.[4]

Currently in Victoria, ACPs have a limited legal status. They should be taken into account, [5] however they may not always be complied with (unlike an RTC). Specific legislation in South Australia, New South Wales, Queensland and the Northern Territory makes Advance Care Directives (ACDs), for future hypothetical illness, legally binding in those jurisdictions. There is an argument for clarifying their legal status in Victoria, and providing patients with a greater say in their future medical management.

However, those framing new legislation in relation to Advance Care Planning would do well to learn from the experience of other jurisdictions and take account of the many

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[1] Northern Health. (2009). ACP in 3-Steps.
[2] Department of Health. (2014). Advance Care Planning: have the conversation. A Strategy for Victorian Health Services 2014-2018.
[3] Perkins, H.S. (2007). Controlling Death: The False Promise of Advance Directives. *Annals of Internal Medicine* (147(1), 51-57.
[4] Perkins, p.52.
[5] Guardianship and Administration Act 1986. Section 38, p.40.

criticisms that have emerged. For many years, most U.S. States have had laws which enforce adherence to ACDs, yet some bioethicists believed as long ago as 2004 that they have failed entirely,[6] and they have been described as 'fundamentally flawed' because they cannot take into account the unpredictability of life and death.[7]

Three major problems with rigidly enforceable Advance Directives are that: (i) they may not be informed; (ii) their interpretation may be difficult; and (iii) they may conflict with the patients best interests.

(i) Advance Directives may not be informed

ACDs may be of questionable validity should patients have a poor understanding of the medical care they are choosing to consent to or refuse, or insufficient information on which to base a decision. 'Many unwittingly misrepresent their wishes in advance directives'.[8] Patients might consent in advance to CPR, believing that the long term survival rates are much higher than they actually are. Or they may have a mistakenly negative view of the prognosis of certain conditions. Further, even when a patient is well informed, the progress of disease, trajectory of health deterioration and development of unanticipated new illness is often unpredictable, and so it 'will often be impossible for the person to predict what treatments will be appropriate and when'.[9] It is also known that wishes expressed when a patient is healthy can change during the course of a serious illness, but the ACD may not have been updated to capture this.

Especially when patients are making a serious decision to forego lifesaving treatment, the decision making process that results in an ACD should be no less rigorous than for a competent patient refusing treatment for a current condition. Therefore, any legislation to enforce ACDs should also ensure that patient's competence to make such decisions is adequately assessed, and that they are fully informed about the relevant medical treatments. This could be a lengthy process. And there might still be doubts about the validity of specific refusals of treatment when circumstances arise that are different to what the patient had envisaged.

(ii) Interpretation may be difficult

Another serious problem with strict enforcement of provisions in an ACD is that in them, patients 'often issue ambiguous or conflicting instructions'.[10] The South Australian Advance Care Directive form has a section for a patient to make binding refusals of particular health care and the accompanying guide contains a number of sample statements, many of which are too general and ambiguous, including 'If I have a serious car accident or illness and I am not likely to recover I would prefer comfort care to maintain my dignity'. 'Comfort care' is defined in the documentation, but it is not clear what 'serious' means, nor what unlikely to recover means (likely to die, or likely to be permanently disabled) and what time frame is envisaged (many serious illness are likely to lead to death, but it may not be for several years). It will be left to the treating doctor and possibly the patient's medical substitute decision-maker to interpret this instruction in any given circumstance. This will be less difficult if the patient has discussed their preferences and values with both of these. Understanding reasons and values that underpin stated preferences can help in the interpretation.

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[6] Fagerlin, A. & Schneider, C.E. (2004). Enough. The failure of the living will. *Hastings Center Report*, 34 (2), 30- 42.
[7] Perkins, p. 52
[8] Perkins, p. 53.
[9] Rosen, L. (2013). Responding to the Challenges of Advance Care Planning. http://rosensunshine.com/responding-challenges-advance-care-planning/
[10] Perkins, p. 53

(iii) Advance directives may conflict with the patient's best interest.

Patients make ACDs on the basis of certain assumptions about the prognosis of certain diseases or injuries, and about their life situation when these occur. But the reality of the situation, when it happens, may be quite different to what they assumed or envisaged - either better or worse. Advances in medical technology and treatment, or the development of new disease processes which were not anticipated, may mean that the decision was based on outdated information that is no longer relevant. The refusal of life saving treatment may no longer be in their best interests or, conversely, consent to such treatment may no longer be in their best interests.

For these reasons, we recommend that rigidly enforceable ACDs, as such, be de-emphasised in favour of a broader approach to Advance Care Planning; one which emphasises the careful appointment of a medical substitute decision maker in the form of an Enduring Power of Attorney (medical) and which encourages the patient to identify and discuss their values and beliefs with family, friends, chosen medical substitute decision-maker and their health care team. This requires 'honest communication; preparation of patients and families for death's harsh and unpredictable reality; mutual support; non-formulaic, individualised care; and courageous decision making despite uncertainties'.[11] The less prescriptive discussion-based approach is actually more likely to result in decisions in accordance with the patient's wishes and values, and so is more respectful of their autonomy.

PROVISION OF ADEQUATE PAIN RELIEF

Sometimes there is uncertainty on the part of doctors, patients and/or relatives agreeing to treatment on behalf of patients as to whether the administration of pain relieving drugs might also shorten the patient's life. Morally, such pain relief is justified by the principle of double effect (PDE), so long as the possible hastening of death is foreseen but not intended. Legally, it is generally assumed, on the basis of the English case *R v. Cox,* that if the doctor's intention is to relieve pain rather than to end life, such treatment will be lawful, on the basis of PDE. However this has not been tested in Australian courts, so there remains some uncertainty. Further, it has been claimed that the current state of the law encourages hypocrisy, with doctors claiming that their intention is pain relief when in fact they intend the patient's death and their practice is really euthanasia. How, it is asked, can someone prove what the doctor's intention really is?

There are two points to be made about this. First**, that there is no evidence that effective pain relief necessarily hastens death,** despite this being widely believed in the community, and often stated in the bioethics literature, as well as in English case law (*In re J (Wardship: Medical Treatment* [1991] Fam 333, 46, per Lord Donaldson MR; R v Cox [1992] 12 BMLR 38, per Ognall J; *Airedale NHS Trust v Bland* [1993] AC 789, 865,867 per Lord Goff) and in the majority opinion of the U.S. Supreme Court (*Vacco v. Quill*). In 1997 two papers were published attacking the 'fallacies' and 'myths' surrounding the use of narcotics in palliative care. Australian Palliative Care physician Michael Ashby's paper stated that the accepted palliative care practice of gradually escalating opioid doses had been used safely for at least 20 years with no evidence that that it caused or hastened death.[12] The other paper affirmed that 'in the majority of cases treatment of pain prolongs life rather than advances

[11] Perkins, p.55.
[12] Ashby, M. (1997). The fallacies of death causation in palliative care. *Medical Journal of Australia*. 166 (4), 176-177.

death'.[13] In other words, the PDE need not be invoked to justify the use of these drugs by skilled and experienced practitioners, because they simply do not have a 'double effect' of causing death as well as treating pain. This was emphasised again in a 2007 commentary in the *Journal Palliative Medicine*: 'Numerous studies of opioids and sedatives worldwide are clear that they do not hasten death or alter survival'.[14] Effective pain relief is not a form of euthanasia.

Second, **the intention of someone prescribing pain relief is not difficult to demonstrate:** 'In practice it is easily determined by looking at the prescription. A competent clinician or specialist will use proportionately small repeated doses titrated to the individual, usually with co-analgesics and non-pharmacological treatments or care, and always with the aim of achieving relief without harm. A single large dose, especially intravenously, with no attempt to minimise serious adverse effects, suggests either negligence or malice'.[15] This of course does not mean that a large intravenous dose of analgesic might not be well-considered, proportionate and required in some circumstances.

Nevertheless, given the remaining uncertainty in some doctors' minds, and the widespread public misapprehension that pain relief may shorten life, it would be wise to clarify in Victorian law that doctors may use medically accepted, appropriate and effective pain relief at the end of life without fearing prosecution, if their intention is clearly to relieve pain and not to end life, and that this intention is discerned not merely by their reported intention, but by scrutiny of the prescribing record. Further, that all medical practitioners should be adequately trained in the administration of pain relief at the end of life.

PALLIATIVE CARE

We need better palliative care knowledge, education and services. A Commonwealth Review in 1997 estimated that less than half of the Australian population, who would benefit from palliative care, receive it. We need to stop seeing people die badly due to lack of palliative services. We need to advance in our understanding of what pain relief works with what illness. Researching and developing new cures is important but should not be resourced at the cost of inadequate basic care and inadequate care when cure is unattainable. Given that one hundred percent of us will die, investment in palliative care has potential to benefit each and every one of us. End of life care requires additional and sufficient funding so that people do not die badly due to lack of palliative services.

Not everyone will require specialist palliative care services, but many people will require clinicians to use a palliative approach to their care. This means applying the principles of palliative care: (i) holistic care that addresses physical, emotional, social and spiritual needs; (ii) knowledgeable use of medicine to relieve pain and other symptoms; (iii) patient and family centred care; (iv) quality communication; and (v) bereavement support. This knowledge and skill will come from teaching by those with specialist knowledge, which means having sufficient specialist palliative care services to provide this teaching, as well as to provide individual clinical care to those patients requiring more specialised palliative care skills.

Patients should not be forced, by inadequate palliative care, into seeking death as an escape from treatable pain and other suffering.

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[13] Wall, P.D. (1997). The generation of yet another myth on the use of narcotics. *Pain* 73 (2), 121-122.
[14] George, R. & Regnard, C. (2007) Lethal opioids or dangerous prescribers? *Palliative Medicine* 21(2), 77-80.
[15] George and Regnard, p.77.

EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE

Euthanasia and physician assisted suicide (PAS) should remain legally prohibited

All societies and cultures have laws against murder, based on the moral belief that it is wrong to kill an innocent human being. The right to life is the most basic of human rights. In the Judeo-Christian tradition, this belief is based on humans being uniquely created in the image of God. But respect for life is not just a religious value, it is a foundational value of all societies in which reasonable people would want to live. It is foundational to what German philosopher Jürgen Habermas calls 'the ethics of the [human] species'.[16]

The general wrongness of killing may be framed in a number of ways, based on the intrinsic value of human life. The life of each individual has an equal claim to respect, because the value and dignity of each person is not diminished by age, disease, dependence or disability.

Nevertheless, as long as some exceptions to the general prohibition on killing are allowed, such as capital punishment, warfare or self-defence, some argue that euthanasia and/or PAS might also be examples of exceptions to the general rule against killing. The two major arguments for permitting these practices, used separately or together, are the argument from the principle of respect for patient autonomy and the argument based on the obligation to relieve suffering where possible.

The argument based on respect for the autonomy of the patient is flawed. To kill another person, even at their request, is to commit an injustice against that person, because the right to life is inalienable, since human life is the good which is fundamental to the pursuit of all other goods, including the exercise of individual autonomy. The banning of duelling and of slavery are other examples of the view that we cannot waive our right to life or freedom, or give permission to anyone to kill or enslave us.

The argument based on the obligation to relieve suffering is also flawed. There may be individual cases where patients' symptoms are poorly managed at the end of life, but generally this is an argument for better palliative care, not for euthanasia. Rarely, physical symptoms cannot be managed, even with the best care. But these are exceptional, and **hard cases make bad law.**

But pain and physical suffering account for only some requests for euthanasia or PAS. Often the request is prompted, not by symptoms which can be managed by medical therapies, but by existential suffering. Coming to terms with impending death, dependence or disability is difficult and distressing. But it is not amenable to a purely medical solution. The real problem with euthanasia is that it is a medical solution to a non-medical problem, an existential or spiritual problem.

Euthanasia cannot and will not be limited to competent patients or to the terminally ill.

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[16]Somerville, M. (2014). Respect for human life? The 'life concepts' informing end-of- life decision-making. http://www.abc.net.au/religion/articles/2014/02/15/3945451.htm

Even more importantly, when the two standard arguments for euthanasia and PAS practices are examined, it is clear that each, if accepted as grounds for making an exception to the general prohibition of killing, would justify a much broader practice of medical killing than is usually sought by its advocates. The two arguments, respect for patient autonomy and the obligation to relieve suffering, are typically used together as a single justification, but they are logically separate. If the justification is respect for patient autonomy, then a request from a competent person is all that is required, and the practices could not be limited to those who are terminally ill. Those with a chronic debilitating illness or disability could ask for euthanasia. It could not be limited to those with physical illness, since emotional suffering is often worse than physical suffering. Even those who have no present symptoms at all but simply wish to avoid the indignity of aging or future illness could ask for euthanasia.

And if the justification is the obligation to relieve suffering, it would apply equally to incompetent as to competent patients, and would justify non-voluntary euthanasia. Even before the law has been changed in Australia to allow voluntary euthanasia (at the request of a competent patient), the argument is being made that dementia sufferers should be allowed to 'die with dignity', meaning that they be killed by lethal injection, not at their own request, but at the request of relatives who say that that is what they would have wanted. That this is so is seen clearly in the changes to the law and practice in jurisdictions where euthanasia and PAS have already been legalised.

In February 2014, Belgium made international headlines when it became the first country in the world to allow euthanasia for children of any age. There are only three countries where euthanasia has been legalized: the Netherlands (2001), Belgium (2002) and Luxembourg (2008). Initially, Belgium legalized euthanasia only for adults in 'constant and unbearable physical or mental suffering that cannot be alleviated.' In the Netherlands, euthanasia is legal for children over the age of 12 if the request is 'voluntary and well-considered', the patient is 'suffering unbearably' with no prospect of improvement, and there is parental consent.

Under the new Belgian law, a child of any age can request euthanasia if they are 'conscious of their decision', have a terminal illness, and are in great pain with no treatment available to alleviate their distress. The request must be approved by their parents and their medical team. A psychiatric evaluation is also a requirement to ensure that the child is not suffering any mental illness and has the required competence—that they understand the gravity of the request. It is argued that because of these strict criteria, Belgium will effectively have an age limit for children (probably similar to that in the Netherlands) and that the criteria are more stringent than for adult euthanasia.

However, there is a great deal of evidence from both Belgium and the Netherlands of the way that the practice of euthanasia is expanded to include more and more of those who would have been excluded from the initially strict criteria. For example, in Belgium last year, Nathan Verhelst, who was born a girl and had been depressed for many years, was euthanised after gender reassignment surgery left him 'disgusted with himself'. Another controversial case involved a pair of 45-year-old identical and 'inseparable' twins who were born deaf and euthanised after blindness began to threaten their ability to communicate with each other.

Even more alarming is the extension of euthanasia practice to very young children including infants and to people with dementia. In the Netherlands, the *Groningen Protocol,* created in 2004, specifies criteria under which physicians can perform 'active ending of life on infants' without fear of legal prosecution. The final decision is in the hands of the parents, with physicians and social workers agreeing to it. Criteria for euthanasia include 'unbearable suffering' and an assessment of 'expected quality of life'. The Royal Dutch Medical Association (KNMG), which represents doctors in the

Netherlands, has said that of the 175,000 babies born every year in The Netherlands, about 650 might be cases which would warrant euthanasia.

Why is it that the legalisation of active euthanasia for competent adults with strict guidelines has so quickly led to the practice and eventually legalisation of active euthanasia for children and even (effectively) infants? Despite the fact that respect for patient autonomy is always front and centre of the argument, it is because advocacy for the legalisation of euthanasia is really not so much about respect for patient autonomy but about a society deciding that it can be—perhaps definitely is—in some people's best interests to die. The new law in Belgium makes this abundantly clear.

Again, the moral logic of the two justifications for euthanasia—respect for patient autonomy and the relief of suffering—demands the extension of the practice beyond both those who are suffering and beyond those who are able to decide for themselves. Hence the argument runs: If adults can have it why can't children who are judged to be sufficiently mature? And if older children, why not younger children and infants? And why not the intellectually disabled and those with dementia? If people who are terminally ill, why not the chronically ill or disabled who are suffering unbearably? If those with physical suffering, why not those with mental or emotional suffering such as severe depression? Why not, as euthanasia advocate Philip Nitschke suggests, the elderly bereaved and the troubled teenager?

Legalising euthanasia and PAS will send mixed messages about suicide prevention.

The euphemism 'assisted dying' aims to mask the fact that euthanasia and PAS are actually forms of suicide. It is incongruous that there are moves in Australia to legalise these practices at the same time as there is so much emphasis on suicide prevention. Suicide is a major social problem, and we rightly spend resources aimed at reducing the suicide rate. Usually when someone is suicidal, we try to help them to live, not to die. If euthanasia and/or PAS were legalised, we would on the one hand be promoting suicide prevention, and on the other, promoting suicide as a legitimate choice. The strength of a sense of obligation on the part of doctors and other professionals to try to prevent suicides will be significantly weakened. Suicide is no less tragic when a person is old rather than young, disabled rather than 'normal', or sick rather than healthy. To approve suicide for some but not others is inherently discriminatory, and indicates that some lives are considered of more value than others.