1. Introduction: The problem of starting with “absolute individual autonomy.”

The Report’s initial focus upon “absolute individual autonomy” means that little ethical consideration is given to communitarian values. The Report reaches its conclusions independently of the discussion of the problematic nature of the individualism that in recent years has been recognized to have had a toxic influence in ethical discussion from the late eighteenth through at least into the second half of the twentieth century.

Effectively, this Report, with its commitment to “absolute individual autonomy” uncritically and perhaps unwittingly accepts an Emotivist ethical position (“you do your thing and I will do mine”), and then struggles with consequential logical inconsistencies as it then seeks to win support for its own conclusions by resorting to a catalogue of emotionally disturbing experiences of extreme end-of-life suffering.

(An outline of the late twentieth century critique of Emotivism and of an ethic of “absolute individual autonomy” in western liberal democratic society generally is found in the full text of this response).
2. The ethical importance of communitarian values:

The Report’s commitment to “absolute individual autonomy” and its concomitant lack of focus on communitarian concerns, is evident in the account of the Committee’s reasoning in relation to the impact that legalized assisted dying might unwittingly give to people contemplating suicide. The Report’s discussion of publicly expressed anxiety about this issue is far from satisfactory:

a. First, the Report notes that the AMAWA (and others) have expressed concern about rising suicide rates in the Netherlands as a result of that country’s end-of-life laws. The Report then adds: “although claims about increased suicide are disputed by other evidence received by the committee (for further information, see chapter 5)”.

b. Then, in Chapter 5, this “further information” is revealed to be reported evidence of the impact of voluntary assisted dying on the incidence of suicide in USA. However, this is the matter that is said to be “disputed.” In USA this issue is therefore unresolved.

c. Then there is a passing reference to the experience in Switzerland, where the incidence of suicide has been falling since 1942. Switzerland is thus taken to provide a counter-instance to what is reported to be the case in the Netherlands. However, this passing reference to Switzerland is left critically unexamined.

d. The AMA’s expressed concerns about the impact of legalized assisted dying in the Netherlands is in this way unfortunately not addressed in Chapter 5. This expressed community concern is thus left hanging in the air.

3. The possible negative impact of legalized voluntary assisted dying on palliative care services.

The Report readily admits that the present chief cause of protracted end-of-life suffering in Western Australia is inadequate access to palliative care services across the State. Its recommendations about
the improvements needed in this area, including the need for more resources to be put into palliative care, the universal provision of palliative care services, and more co-ordination of palliative care services across the State, are to be enthusiastically welcomed.

However, the Report itself does not register any awareness of the fact that there is an implicit logical tension between its very welcome findings in relation to the need for more palliative care services in Western Australia, and the argument for the alleged need for voluntary assisted dying. For it seems a matter of simple logic that the legalized provision of the option of assisted dying would clearly lessen the need for the universal provision of such services, and thus lessen the public pressure to improve the provision of such services. It would in fact be a cheaper option.

As a consequence of the availability of voluntary assisted dying, the community’s commitment to the aim of achieving the goal of the universal availability of palliative care services will necessarily be weakened, if not insidiously undermined.

That this is not just a theoretical or notional concern is indicated by anecdotal reports of the deterioration of the provision of palliative care services in the Netherlands since the legalization of voluntary assisted dying.

4. The possible negative impact of legalized voluntary assisted dying on pain relief research and development.

In a similar way, once a community embraces legalized assisted dying it seems to follow that it no longer really needs to be too concerned about finding more refined and effective pain killing drugs for use in end-of-life treatments and care. If voluntary assisted dying is used as an alternative to the treatment of pain how can it be otherwise?

It is therefore a legitimate question as to whether the availability of legalized assisted dying may have the negative effect of taking the foot off the accelerator in relation both to the funding of improved
palliative care services and to the support and development of pain control research.

5. Shortcomings in the Report’s handling of the “slippery slope” argument.

Will there be a “slippery slope” from the restricted provision of assisted dying to residents of Western Australian who are adults in a terminal and irremediable condition of pain and suffering to include minors, mentally depressed people, or simply aged people experiencing diminished “quality of life”? While it is admitted that Belgium might have moved towards further development of the legislation (including allowing minors to decide to end their lives as well as adults) this is said not to have happened in Oregon, in the USA. Once again a counter-instance is cited as though this amounted to a conclusive argument. On these grounds “the slippery slope” towards the extension of the availability of voluntary assisted dying is therefore said not to be a pre-determined inevitability.

However, whilst not being an inevitability there is logical pressure already implicit in the principle of “absolute individual autonomy” towards the possible extension of the legislation. Why exactly should the suffering of an 18 year old person in a terminal and irremediable condition be somehow different, and in medical terms handled entirely differently, from the suffering of a 17 year old person in a similar terminal and irremediable position? This is an implicit danger of starting with an ethic of “absolute individual autonomy.” That a slippery slope is not an inevitability does not mean it no longer remains a concerning possibility.

6. The official stance of the AMAWA against legalized assisted dying.

Both in its written submission and when giving evidence at hearings, the AMAWA frankly stated that it is opposed to the introduction of assisted dying in Western Australia. (Submission No. 685 from Dr Omar
Khorshid, President, Australian Medical Association (WA), 15 February 2018, p. 1; and again, Dr Omar Khorshid, President, Australian Medical Association (WA), Transcript of Evidence, 18 May 2018, p. 13).

This quite unequivocal stance of the AMAWA is understandable, given the importance of the Hippocratic oath in the long history (since 470BC) of medical profession’s commitment to the alleviation of suffering and the saving of life, rather than to the deliberate and intentional bringing of life to an end. It is understandable that members of the medical profession do not want the basic trust that the community relies upon in consulting them to be compromised. However, the report does not address the community concern that involvement of the medical profession in the termination of life will over time erode the community’s basic trust in members of the medical profession always to act to alleviate pain and to save life rather than to terminate it.

Indeed, the AMAWA is of the view that, should voluntary assisted dying be made legal, a request for assisted dying should go to a panel for approval, in view of the fact that individual doctors are not best positioned to make these types of end-of-life assessments. (AMA transcript of evidence to the Committee, 18 May 2018). The Committee therefore recommends that there will be no compulsory involvement.

Apart from this concession, the expressed position of AMAWA appears not to have been taken very seriously. If anything, the Report’s commitment to the ethic of “absolute individual autonomy” unfortunately leads to a tendency to disparage the role of the medical practitioner in end-of-life decision-making. It is suggested, for example, that the “absolute autonomy of the individual” means that the patient should ideally be independent. This independence is said to extend to the point where the patient should therefore be free even of dependence on the medical profession. The idea of autonomy is thus said to have displaced the idea that “the doctor knows best.”
Absolute independence in end-of-life situations is in this way implicitly valued above dependence on the medical profession. However, there is really no ethically based discussion in the Report of why independence is to be so valued. Dependence upon the medical profession cannot simply be assumed to be a bad thing simply because it allegedly impinges on “absolute individual autonomy.”

7. The importance of the ethical “law of double effect” implicit in current medical practice, and the legitimacy of resort to “palliative sedation” when necessary.

The long-standing ethical principle of “the law of double effect” has been appealed to at least since the thirteenth century. In relation to end-of-life medical care, the law of double effect allows us to hold that even if, by administering drugs with the intention of alleviating pain, life is thereby shortened (and even ultimately ended by the so-called “lethal dose”) such treatment is nevertheless ethically justified and permissible.

The Report tacitly approves of the operation of this principle in current medical practice and finds that there is no need to change the current protections of Sec. 259 of the Criminal Code for members of the medical profession whose pain killing treatments may ultimately contribute to the hastening of death. These findings of the Committee are to be welcomed.

Likewise, the need to resort to “palliative sedation” in order to control pain is tacitly acknowledged. Indeed, the Report is critical of the tendency of some doctors to under-medicate their patients. (The evidence of Case Study 4.1 on p.127-8 of the Report is crucial to this discussion).

This is the most useful and coherently presented section of the Report, which in fact goes on to recommend improvements in these current medical procedures, including the need to discourage under-medication due to possible confusion about imagined legal implications of “palliative sedation.” Sometime “palliative Sedation” is
referred to as “Terminal Sedation”. Though unfortunately the Committee opts for the term “terminal sedation,” it recommends that this made subject to mandatory reporting.

8. Why then is voluntary assisted dying still thought to be necessary?
Given these recommended improvements in current medical practice, and the Report’s clear recommendation that the inadequate provision of palliative care services across the State of Western Australia should be urgently addressed and rectified, a logical question arises: Why in this case, is the legalization of voluntary assisted dying be really necessary? Clearly the AMAWA already believes that it is not necessary, even before the implementation of the Report’s recommended improvements in current medical practice.

This question becomes all the more pressing given that the Report identifies the inadequacy of the provision of palliative care services in Western Australia as the “chief cause” of contemporary perceived need for voluntary assisted dying. The Committee is to be commended for correctly addressing what it identifies as the cause of the problem with which it is concerned. Once the chief cause is addressed in the helpful way the Committee recommends, however, a question is begged about why there should be a continuing justification for the legalizing of voluntary assisted dying?

9. The negative impact of the Report’s initial commitment to “absolute individual autonomy” on its assessment of these current medical practices.
At this point the troublesome operation of the Committee’s initial commitment to the ethic of “absolute individual autonomy” becomes evident. For at this point the Report does not argue a case for the inadequacy of current medical practice, let alone its continuing foreseeable inadequacies even with the implementation of the Committee’s own recommended improvements. In a sense, without
statistical evidence relating to the current practice of “palliative sedation” and its effectiveness or otherwise (which the Report commendably seeks to rectify by recommending mandatory reporting) it is hard to see how such an argument could be mounted. Likewise, the inadequate provision of universal palliative care services across the State, and their lack of co-ordination, which the Committee itself identifies as the chief cause of the current perceived need for legalized assisted dying, surely needs to be addressed before an argument for acting to legalize it could hope to be sustained.

Instead of demonstrating a need for immediate action to legalize voluntary assisted dying, the Report simply moves on to discuss the experience of assisted dying legislation in other countries.

We thus have to take the Report at its word: there is no reasoned argument why current practices must necessarily and immediately be replaced or complemented by voluntary assisted dying: instead, the Committee has to rely on the ethical principle of “absolute individual autonomy” to warrant the alleged right of an individual to legalized assistance in terminating his or her own life. As the Report forthrightly says: “Individuals exercise independence and autonomy in their daily lives and want to be able to make autonomous choices when they are dying. One of those choices should be to manage the place and time of their own death, through voluntary assisted dying.” The logical short-fall of this Emotivist position is abundantly clear.

10. A fundamental lack of terminological clarity.

Finally, the Report speaks of those in a “terminal and irremediable condition” of pain and suffering without clearly defining these terms. Pain is a physical sensation; suffering is a psychological condition in which one wishes that one’s situation were other than it is, but it may or may not involve pain. One can suffer because of a bereavement, or unrequited love, embarrassment, or public misrepresentation of one’s character by defamation. Clearly, we can share one another’s suffering; we cannot share one’s another’s physical pain.
Unfortunately, the Report does not distinguish the logic of “pain” on one hand and “suffering” on the other.

This means that some of the Report’s references to the alleged need for legalized voluntary assisted dying open the way for any adult person who is resident in Western Australia “to determine his or her own time and manner of death” if he or she is in a condition of terminal and irremediable suffering, and has received a diagnosis with a prognosis of death within the “foreseeable future” (roughly, the next six months or so), even in the absence of physical pain. The Report’s proposal in this case would probably achieve much more than is intended.


Finally, it is important to note that talk of the exercise of “individual autonomy,” despite its apparent capacity to beguile us into thinking that it might constitute a legitimate ethical argument, is in fact irrelevant to the question of the appropriateness or otherwise of “voluntary assisted dying,”

In other words, though the principle of “individual autonomy” is often called upon to give some kind of ethical respectability to “voluntary assisted dying” with its appeal to individual rights and freedoms, it is in fact an ethical “red herring.” The argument that leads to this inevitable conclusion may set out in three steps:

a. First, I would be surprised if anyone would disagree with the contention that we could hardly justify acting on a request for assistance in injecting a person with heroin on the ground that he or she wished to exercise his or her “individual autonomy” by freely deciding to become an addict. In this circumstance we would certainly be ethically right in refusing assistance. Who
would think otherwise? Even trial “injecting rooms” are designed to save life - in the hope of giving people time and opportunity to shake free of addiction and to live. Assisting a person to become or remain an addict on the grounds of his or her right to exercise “individual autonomy” is clearly an entirely spurious argument.

b. This means that the justification of “voluntary assisted dying” really has nothing to do with its alleged “voluntariness,” even if this is often cited as the basic justifying reason (as in the Report of the WA Select Committee). Clearly, despite the protestations of the Select Committee’s Report, the real reason for supporting “voluntary assisted dying” has to do not with a principle of “individual autonomy” but with the alleviation of anticipated protracted pain and suffering. “Voluntary assisted dying” is thus an alternative to palliative care, utilizing palliative sedation, backed by the ethical principle of double effect, as in current medical practice in end-of-life situations.

We have frankly to acknowledge that “voluntary assisted dying” is resorted to in circumstances where a patient is experiencing diminished quality of life to the point where it is judged (by the patient him or herself and by others) that his or her life is “not worth living,” This is actually a “quality of life” argument which is quite independent of talk of the exercise of “individual autonomy.”

c. Alas, it is disturbing to note that this very same “quality of life” reasoning—the relief of anticipated pain because of diminished quality of life when life is judged to be “not worth living” — may also be said to warrant involuntary or non-voluntary assisted dying. (Involuntary when it is contrary to a patient’s conscious wishes; non-voluntary when a patient is incapable of expressing any wish. eg. a baby, or a comatose patient).
In other words, as soon as this “quality of life” argument is espoused it has to be acknowledged that it could also apply to babies born with Spina Bifida, perhaps to Down Syndrome babies, in some places to baby girls (eg. not just ancient Sparta but in modern China), mentally retarded people, the senile and the demented, the severely incapacitated and those who are unable to enact the full range of behaviour that is typical of healthy human beings, and on and on. In all kinds of cases, and not just in end-of-life situations, a life could be judged to be a “life not worth living.”

Clearly, in order to be consistent, we are obliged to acknowledge that if a “quality of life” argument is brought to the justification of “voluntary assisted dying” it can also apply to non-voluntary and even involuntary assisted dying. And this transition is easily made, as was demonstrated in Nazi Germany where even doctors were beguiled into thinking that life was “no longer worth living” not just (as at first) in the case of the the severely handicapped and chronically sick, but (eventually) in the case of the socially unproductive, the ideologically unwanted, and even women and children suffering malnourishment, illness, and misery in concentration camps.

It is important to note that this is not a scare-mongering “slippery slope” argument; it is not suggested that what happened in Nazi Germany will also happen here. It is rather that the same argument was used in Nazi Germany as is at present used in contemporary argument in support of voluntary assisted dying. Given that this “quality of life” reasoning was obviously wrong in Nazi Germany, this same argument is just as wrong in contemporary Western Australia.

On the other hand, it is of some concern that the Report of the Remmelink Committee that reviewed euthanasia in the Netherlands
(between 1990 and 2005), noted that when asked in 1990 and again in 1995, 50% of medical practitioners in the Netherlands said that they had or that they would be prepared to go ahead with assisted dying even without a patient’s explicit request. In one sense, this, appears to be a logically reasonable position, for, obviously, the justifying reasons for foreshortening periods of pain, is actually the same, whether assisted dying is voluntary or non-voluntary, or involuntary. So there is huge logical pressure, should voluntary assisted dying be legalized on these grounds, to move beyond it to non-voluntary and involuntary assisted dying. Clearly, it is important to acknowledge that it is ethically wrong in the first place.

12. Conclusion.

Clearly, this Report “My Life, My Choice”, however well intentioned, is light on logical coherence, deficient in terms of rational ethical argument, and far too heavily reliant on a commitment to the questionable notion of “absolute individual autonomy.” This means it relies implicitly on an Emotivist ethic of individual rights without due consideration being given either to the actual wishes of the medical profession, as explicitly expressed by the AMA in Western Australia, and irrespective of the possible negative social implications of such a measure for the wider interests and concerns of the community. This is hardly an adequately convincing basis to warrant legislative change in such an important area of human life.

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