Should there be a legal right to die?

A discussion about the Voluntary Euthanasia Bill 2009 (WA)

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Introduction – Framing the Question

For reasons that will appear, I am grateful to the organisers of today’s conference that the question has been posed in the form “should there be a legal right to die?”. Often there is, in the debates about “rights” in our community, an assumption that “rights” are not created by our legal system but exist independently of that system and are only “recognised by it”. According to this approach, the question today would be: “is there a right to die?”.

The difference is important.

The original draft of the Voluntary Euthanasia Bill 2009 (WA), for example, purported to answer the latter question, when it said in clause 3(1):

“It is the purpose of this Act to:

(1) recognise the right of an adult person to intentionally terminate his or her own life in the circumstances set out in this Act; ...” (My emphasis)

The use of the word “recognise” here, rather than “create” or “confer”, was, I argued at the time, quite deliberate. It reflected a view that the right referred to was something which fundamentally already existed and which the Bill was simply “recognising”. I therefore started, then, from the proposition that the proponents of the Bill considered that legislating to “recognise the right of an adult person to intentionally terminate his or her own life in the circumstances set out” in the Bill was the “right” thing to do; indeed that not to do so would be “wrong”.
It is something of a pity then that the current form of the Bill has a new purpose, which is, with respect, a model of Orwellian doublespeak:

“It is the purpose of this Act to provide immunity from criminal or civil liability to a person who does or omits to do any thing that is required to give effect to the provisions of this Act, provided that what is done or omitted to be done, is done in accordance with this Act.”

I think this means: “the purpose of the Act is to do what the Act does”. I must say I preferred the old purpose which, at least, had the courage of its convictions and articulated a “purpose” with which one could rationally agree or disagree.

But it does, at least, get us back to the question what “rights” we should have: how we get them and why we should have them.

“Right” versus “Rights” – a Brief Etymological Detour

The Greeks, it seems, did not have much use for a concept of “rights”\(^3\). They were content to use the concept of “justice” and the standard of the just (“dikaion”). The word we translate as “right”\(^4\) comes from the Romans, namely the latin word “ius”.

Consistent with Greek philosophy, however, the concept behind “ius” meant a very different thing to the original Romans, Jews and Christians than it means to us today. Ius, in classical and medieval thought, was confined to an “objective state of affairs” and not a subjective interest of the individual human subject. When Thomas Aquinas, following Aristotle, concluded that “right is the object of justice”\(^5\), he meant “right” as the achievement of an objective outcome, not the vindication of a personal interest. “Right” in this sense is the opposite of “wrong” – not the opposite of “duty”.

By the 16\(^{th}\) and 17\(^{th}\) century, however, there was a “shift” from “ius” as a thing “out there” to “ius” individual rights “in here” (said beating one’s breast). The villains of that story (depending upon your point of view) were a Franciscan friar and a Jesuit priest, William of Ockham and Francisco Suarez S.J.\(^6\). By the end of their work, there had been a fundamental shift:
“from a concept of *ius* as what is just, to a concept of *ius* as a moral power (*facultas*) which every man has, either over his own property or with respect to what is due to him”?

Following this shift, the notion of subjective “rights” was able to find its full expression in the writings of John Locke⁸, in time for the great “declarations of rights” in the United States of America (the Declaration of Independence) and France (the Declaration of the Rights of Man and Citizen) in 1776 and 1789 respectively.

While I will defer those more qualified, my limited understanding suggests that, on the matter of “rights”, the *Torah* stands on the side of Aristotle and Aquinas, rather than Ockham, Suarez and Locke. Ernest Fortin, for example, has:

“stated emphatically that the bible had never heard of rights in the Lockean sense, and that when *ius* is used some 30 times throughout the scriptures it is always to designate some legally sanctioned arrangement, such as a right of burial after Abraham’s purchase of a tomb for Sarah.”⁹

What this history highlights is the risk that the radically subjective nature of “rights talk” can miss the more fundamental question of whether the rights we claim or seek are actually “good for us”. When we consider our laws, therefore, we should start, not by identifying the standard against which to measure our laws as the “rights” of the individual, but as the “good” of the individual; those things referred to by philosophers as “the goods of human flourishing”, such as health, knowledge, play, the experience of beauty and friendship.

One of these human goods, no doubt, is freedom (we might also call it autonomy or choice). To flourish, as humans, we must be free – although there is a debate as to whether freedom is an *intrinsic* good (i.e. something rightly to be desired for its own end) or an *instrumental* good (i.e. something necessary for the achievement of other “goods”).

The point is, however, that autonomy is only one human good. The radical subjectivity of our “rights talk”, however, can sometimes blind us to this fact. Rather, in most of our debates about law and justice, the modern tendency is to see choice itself
(autonomy), and not what we choose, as the ultimate human good. David Bentley Hart put the matter this way:

“[W]e live in an age whose chief value has been determined, by overwhelming consensus, to be the inviolable liberty of personal volition, the right to decide for ourselves what we shall believe, want, need, own or serve. The will, we habitually assume, is sovereign to the degree that it is obedient to nothing else and is free to the degree that it is truly spontaneous and constrained by nothing greater than itself. This, for many of us, is the highest good imaginable. ... For us, it is choice itself, and not what we choose, that is the first good, and this applies not only to such matters as what we shall purchase or how shall we live. In even our gravest political and ethical debates – regarding economic policy, abortion, euthanasia, assisted suicide, censorship, genetic engineering, and so on – “choice” is a principle not only frequently invoked, by one side or by both, but often seeming to exercise an almost mystical supremacy over all other concerns.”

Costas Douzinas said of this “notion of the human subject as the sovereign agent of choice”:

“This atomocentric approach may offer a premium to liberal politics and law but it is cognitively limited and morally impoverished.”

The atomocentric approach is “cognitively limited” because it fails to grapple with any standard with which to identify what is “just” or what is good for us. That such a standard is necessary (unless one is either the crudest majoritarian or a nihilist) should be obvious. As Alasdair MacIntyre pointed out:

“Rational debate over the application of moral, indeed, more generally, of evaluative concepts, requires that there be some standard, independent of the desires, preferences, and wills of the contending parties, to which appeal can be made in trying to show why the reasons supporting one point of view are superior to those supporting another. In the absence of such a standard, there is nothing to distinguish genuinely rational moral or evaluative disagreements from any other clash of conflicting desires, preferences, and wills.”

Debate over whether a particular legal “right” is good for us, or not, must therefore identify the human “goods” that are involved. A modicum of reflection ought to make it clear that “autonomy” cannot be the only human “good” nor, even, can it be the highest of those goods."
Our autonomy must be directed, surely, at some higher good or goods (be they happiness, friendship, knowledge, beauty etc). It would be an odd result, to say the least, for us to conclude that something is good for us, simply because it is something we can do.

Similarly not all “rights” are ultimately “good for us”, even if they might on occasion bring us temporary pleasure or gain. Sometimes “rights” are positively bad for us.

Identifying the “goods” of human flourishing, in turn, directs our attention to our relationships with each other. This is because real people, in the real world, are not merely accidentally but essentially related to others, in a wide variety and network of relationships, many of which are given, not chosen. The human person, in the real world, is constituted by those relationships and importantly, for present purposes, our rights can only ever arise from (and be derivative) of those relationships.

When we talk about the “law”, it is also necessary that each such relationship be situated within the broader relationship of the community as a whole, which must itself (if rational debate is to be possible) be based on some agreed conception of the human goods to which that community is directed to protecting or promoting.

Accordingly, before beginning to talk about whether any rights, and in particular, the “right to die” are good for us, it is necessary to immerse ourselves in the complicated network of human relationships that make up the community, arrive at some conception at the good or ends of those relationships and then determine what laws will best suit those ends.

Some of Our Rights and the “Goods” that they Serve

Can I illustrate the above discussion by looking at one or two of the “rights” our legal system provides, the “goods” that they serve and the role that “autonomy” plays in them?
Take “the right to freedom of religion”. Why should we believe in this as a basic “right” given that, even the most “religious” amongst us must concede that that freedom can result in people adopting beliefs that are absurd, abhorrent or worse? What possible good does it serve? The answer comes, in part, from the fact that the basic good to which it is directed – namely religion, or its modern simulacrum “spirituality” - is a reflexive good; that is, a “good” whose value is depends upon it being freely chosen:

“Among the more fundamental, extrinsic ends for which autonomy is instrumentally valuable are reflexive goods, ‘objects of choice whose value is dependent upon their being freely chosen’. Coerced friendship and religious adherence, for example, lack all intelligible value. Only if autonomously chosen does a friendship (even, or especially, with God) make sense as a reason for action. So if friendship and religion are basic goods, they are reflexive in nature.”

This provides an example where the intrinsic good (“religion”, “awe”) requires the instrumental good of “autonomy”.

Closer to the issues in the present case, consider the “right to refuse medical treatment”. The law, as it currently stands, was recently summarised by Martin CJ in Brightwater Care Group (Inc) v Rossiter [2009] WASC 229. In that case, his Honour stated, at [26] “an individual of full capacity is not obliged to give consent to medical treatment, nor is a medical practitioner or other service provider under any obligation to provide such treatment without consent, even if the failure to treat will result in the loss of the patient's life”.

The right to refuse medical treatment, is again, a right necessary for the preservation of certain other goods, and in particular to the “good” of the relationship between a patient and his or her doctor.

The “right” for the patient to refuse medical treatment is what underlies, for example:

1. The need for a patient to give informed consent to any medical procedure or treatment; and
2. The requirement for a medical practitioner to provide advice and warnings as to the risks associated with a particular procedure (see *Rogers v Whitaker* (1992) 175 CLR 479 at 489).

These principles would, ultimately, not make any sense unless the patient remained able to chose whether, or not, to undergo the procedure in question. The right to refuse treatment, therefore, is necessary for the “good” of the relationship between the doctor and patient. In order to preserve that “good”, the law makes no pretence to, nor does it adjudicate upon, the relative value of a human life or the reasons for the exercise of a person’s choice. Rather, the principle “is applied without regard to the reasons for the patient's choice, and irrespective of whether the reasons are rational, irrational, unknown or even non-existent”.

Notice one further thing about the right to refuse medical treatment. The “right” is fundamentally important even where (and perhaps especially where) it is not in fact being exercised. This is because the right forms the backdrop to the relationship between the doctor and patient. So even when I do choose to undergo treatment, and indeed before I even enter into the decision making process concerning some medical treatment, I do so safe in the knowledge that it is my choice to do so. My right not to do so underlies the good of the relationship between me and my doctor.

In this way, it may be seen that when thinking about whether our rights are “good for us”, we must look beyond the immediate circumstances in which they might be exercised. We must also look to how the existence of those rights, in turn, affects the nature of our relationships generally and the way in which we see ourselves.

The law, and our rights, therefore feedback into the way we see ourselves, our lives and the lives of others. So, when discussing a particularly proposed law, or proposed right, it is necessary, when identifying the effect that those laws will have on the “goods” of human flourishing, to adopt as broad a perspective as possible.
The effect of the Voluntary Euthanasia Bill 2009 on human “goods”

I want then, for the purposes of discussion, to raise a number of the human “goods” to which voluntary euthanasia might be said to be directed (either positively or negatively).

The “goods” I want to raise for discussion are:

1. Autonomy;
2. The relief of suffering;
3. The intrinsic value of human life (this might also be called our “relationship with our selves”); and
4. Our relationships with others (particularly doctors, family and friends);

The principle positive “good” to which euthanasia is said to be directed is, of course, the “relief of suffering”. As this, it seems to me, is the most difficult for me to answer, I have left it to last. The other “good” cited by proponents of voluntary euthanasia is “autonomy” or “choice”. I have already touched in this (and the way in which it is a “good”) but it is worth exploring in a little more detail.

The Good of Autonomy

In large measure the Bill wants to be seen to be solely about respecting individual “autonomy”: that is, to affirm the fundamental sovereignty of the individual to choose the time, place and manner of their death. Indeed, the entire rhetorical program surrounding voluntary euthanasia is built around the practise being “voluntary”; that it is all about the “choice” or “will” of individual persons and will not, and cannot, have any adverse effect on those who do not choose the path made available by it.

This is, superficially at least, very powerful rhetoric and, given what is said above about the “mystical supremacy” of choice, an argument that is extremely difficult to see past. Autonomy is, as I have said, a human good.
So rather than argue about whether unrestrained autonomy is a good thing, I want, rather, to suggest that to the extent that “autonomy” is said to be the “good” of voluntary euthanasia, the *Voluntary Euthanasia Bill 2009* manifestly fails to uphold it.

First, in one critical sense, voluntary euthanasia is not about autonomy *at all*: it is not about leaving people free to decide and to act in the way they choose. Insofar as the “right to die” is concerned, there is in truth no prohibition against a person taking their own life. Rather, at the very centre of the *Voluntary Euthanasia Bill 2009* is not a lone person choosing to die but a medically endorsed decision to kill. This may sound melodramatic – it is not meant to – but it is critical to understanding the *Bill*, to see that what is introduced is a medically sanctioned process of assessment and deliberation by doctors, the end result of which is administration by the doctor of drugs intended to cause the death of the patient. This is not the legalisation of a purely private act of choice but the creation of a complex set of social and legal relationships. We should not pretend it is otherwise.

By creating that set of social and legal relationships, the *Bill* may also (paradoxically) have the effect of *displacing* the autonomy of the individual. By placing the decision to die into the medical framework, the *Bill* seeks, in effect, to transfer the evaluative responsibility for the decision to the medical professional. Elizabeth Kristol, in the American context, put it this way:

> “Yet the “right to choose” is precisely what assisted suicide is not about. The unique service offered by professional suicide assistants is actually an escape from the burden of autonomous choice ... [T]he ultimate responsibility for taking one’s life ... can be validated by a doctor, an expert we have come to entrust with a wide range of decisions regarding our wellbeing.”

In this way, the *Bill* does not, as its proponents sometimes put it, concern the most private, intimate decision imaginable: On the contrary, whenever we make laws, and especially when those laws draw in whole professions to underpin a particular practice, we are doing (and saying) something very *public*. 
The second, although closely related, way in which the Bill is manifestly not about autonomy is the fact that the Bill balks at allowing euthanasia for any reason. The Bill, at least implicitly (and I would argue explicitly) requires legitimate or persuasive reasons for euthanasia. This desire for reasons, or justification, inevitably entails bringing into the law the notion of objective criteria. Objective in the sense that they are not determined exclusively by the will or desire of the individual applicant for euthanasia but, rather, are adjudicated upon by an external objective standard.

How does the Voluntary Euthanasia Bill 2009 do this?

First it prescribes the “conditions” or “criteria” for a request for euthanasia\(^1\). Secondly, it requires medical practitioners to “assess” and “endorse” the satisfaction of those criteria\(^2\).

Of these criteria the most significant appear to be:

1. A medically-diagnosed illness or condition, the normal progress of which will cause death in two years\(^3\);

2. Pain, suffering or debilitation that is experienced as a result of the progress of that illness or condition; and

3. The absence of a state of clinical depression or anxiety.

Without each of these criteria voluntary euthanasia is not to be permitted, even if it is desired (no matter how strongly or sincerely).

Why should this be so?

On what grounds is euthanasia to be made available to a person suffering pain as a result of an illness that will result in their death within 2 years but not made available to a person whose death will not result for 5 years\(^4\)?
More importantly, why should the right to die be denied to a person who will never die of their illness or medical condition? Or a person who has no illness at all but is simply bored with life, no longer has any friends or family or has achieved all that they wish to achieve in this life?²³

Clearly in relation to such persons, the “right to die” or their individual “autonomy” to determine the time, place and manner of their death is not to be accorded recognition (or respect) by the State. For those persons some other, unstated, consideration overrides their right to self-determination. In those cases (i.e. those outside the objective criteria of the Bill), Parliament (the community) says, “This life has a value which overrides the autonomy of the life concerned. It is to be lived, regardless of whether the person who is living that life agrees”. I, for example, not having a terminal illness, would be prohibited under the regime of the Bill from exercising the “right to die”.

So ultimately, I want to suggest, the “good” of autonomy is not what is at stake in the Voluntary Euthanasia Bill 2009.

The intrinsic value of human life – “All humans are quite useless”
Strangely enough, my premise here as to the existence of the human “good” might be denied by some, so I should state what I mean by the “intrinsic value of human life”.

By “intrinsic” value I mean: having worth for its own sake. To use a Kantian register, something has “intrinsic” value if it is an end rather than merely a means. By contrast, something which is only of value because it is a means to something else has what may be called “instrumental” value. Money, for example, has instrumental value. Oscar Wilde’s aphorism that “All art is quite useless” should, for this reason, be understood as an affirmation of art’s intrinsic, rather than instrumental, value.

To say that a human life has intrinsic value is therefore to say that it has a value that cannot be reducible to its utility; that is, whether it is economically, socially or
culturally productive. This is not to deny that human life can also be “instrumentally” valuable: most of us are of use to each other in various ways at various times. The crucial point is that human beings are not simply the sum total of their usefulness. There is a value to each human that cannot be explained in terms of utility (of any kind).

A person may choose to deny this premise (and no doubt many have). It remains, however, a deep intuition in us and one which, ultimately, forms the intellectual apparatus for a lot of the conclusions we reach in relation to justice, human rights etc. It is not something to be jettisoned lightly.

I want to suggest, however, that it is fairly clear that laws such as the Voluntary Euthanasia Bill 2009 deny this premise.

This is because, by the identification of the objective criteria for the administration of euthanasia, the Bill, in some circumstances (that is, those contemplated by the objective criteria of the Bill) the Parliament (the expression of the community) agrees that “It is right, and proper, and reasonable, to regard non-existence as preferable to this human life”. But, as also point out above, it says to others (those outside the objective criteria of the Bill) “No, this life still has value. It is worth living, regardless of whether you, the person living that life, agrees”.

The differing judgment must be saying something about the “value” or “worth” of the life in question. This is because these objective criteria apply regardless of the desire or “will” of the person in question. As a matter of the operation of the law, they are what are called, in legal terms, conditions precedent to the exercise of the decision by the applicant for euthanasia. They are assessments of “value” (or “value judgments”) which logically precede the question of the individual’s desire.

The value judgments inherent in the Bill, as to the value and respect to be accorded to each particular human life, must apply regardless of the will or desire of the particular individual concerned.
Take two people, John and Jane. Assume, by reference to the objective criteria prescribed by the Bill, that:

1. They have an identical medically-diagnosed condition, the normal progress of which will likely cause death in two years;

2. The pain they experience as a result of the progress of that illness or condition is identical; and

3. Neither is in a state of clinical depression or anxiety.

Assume also that we know nothing of their “desire to continue living”.

By reference to the objective criteria the Bill identifies, the Parliament says, to both John and Jane: “It is right, and proper, and reasonable, to regard non-existence as preferable to your human life”.

Perhaps John has no “desire to continue living”. Perhaps Jane does. We do not know. What we do know, however, is that the Bill, the Parliament and (through it) the community offer the same objective judgment of their existence and, even more importantly, refuses to make the same judgment about other people in the community.

The Law then, explicitly and objectively, concludes that one human life has a value that another does not.

Again, this conclusion cannot be avoided by reference to autonomy and choice. Unless the Voluntary Euthanasia Bill 2009, and its proponents can stare straight into the abyss and accept the premise that no human life has an intrinsic value (and allow everyone the “right to die”), it is unavoidable that the law, if enacted, will have enshrined a policy of “ranking” the value of human lives.
Judging by the feedback I have received, proponents of euthanasia respond to this conclusion in one of only two ways:

1. The frank acceptance that, in their view, no human life does have an intrinsic value and that everyone should have the right to a lethal injection; or

2. The (often hostile and offended) objection that I must have missed something in the argument, because proponents of euthanasia (being the compassionate ones in the debate) could not possibly be accused of denying the intrinsic value of human life.

It should be obvious that, in my view, while morally repugnant, only the former of these responses is intellectually honest and logically rigorous.

That latter response is more difficult to address. The moral intuition (that life has an intrinsic value) remains, but it cannot seem to get a foothold in the logic of the argument in relation to euthanasia. So what tends to happen is that the dissonance between the moral intuition and logic is pragmatically sidestepped by saying that all this philosophising is unnecessary, and “can’t we just get on with the business of relieving suffering”\(^{26}\).

This is a problem, I want to suggest, because we should be very careful about decoupling that moral intuition from what we are actually doing with our laws. We should, rather, think long and hard about the coherence of our laws. This is because, with time, unless our deepest moral intuitions are “embodied” in our laws, they will inevitably atrophy.

Finally on this point, I also described this good as our “relationship with our selves”. This brings us back to the notion that the existence of a particular “right” will be important (and perhaps especially so) even where it is not in fact being exercised; because it forms the backdrop to the nature of our relationships generally and the way in which we see ourselves.
If we adopt, even by default, an “instrumental” rather than an “intrinsic” view of human value, it will teach us certain things about the value of our lives and of the lives of others. This will form part of the “wider cultural and societal context” in which we live, which in turn, will affect our decision making:

“The scope and effectiveness of decision-making, in any society, are always constrained by the wider cultural and societal context people live in. An apparently rational personal choice based on health outcomes can often be blocked, for example, by a need to enjoy solidarity with others, or to follow traditional practises as defined by figures of authority, or to avoid ostracism arising from appearing to be different or from appearing to be like a member of an out-group. Even the existence of choice itself, including the conceivability of doing something other than what is usually done, or the acceptability of being open to learning new health-related information and new practices, can be denied to individuals by their social world.”

Moreover, there is no reason to suppose that those lessons can, ultimately, be compartmentalised into a particular medical practice (called euthanasia). A view of human nature which toys with the “value” of individual lives will necessarily feed into the way we view issues of economics, politics and justice.

**Our relationships with others**

I have already identified, in part, some features of the doctor-patient relationship that are reflected in our laws. I just want to highlight two additional things.

The way our law currently operates, it seems to me that there are two interrelated features that are critical to the doctor-patient relations:

1. Respect for the “good” of the patient (both their health and their autonomy) by the doctor; and

2. Trust, in that respect, by the patient.
As I have already said, the first of these is what underlies, the right to refuse medical treatment and the common law duties of doctors, including the requirement for a medical practitioner to provide advice and warnings as to the risks associated with a particular procedure.

In that context, however, the doctor is concerned with the good of the human “life”, even where that human life is ending. The law, as it presently stands, does not make any assessment that some lives are intrinsically valuable and others are not; to the contrary it is directed to recognising the equal right to bodily integrity of all lives.

Similarly, the law, when dealing with the treatment needs of patients entering the final stages of their lives, in no way seeks to pronounce upon or assess the “value” of their lives vis-a-vis other patients. Importantly, it refuses to make such judgments even where the treatment of the patient may have the effect of hastening their death. This effect, of course, may occur most obviously in the case of medical treatment which is administered for the purpose of relieving pain and providing comfort to a patient but which may have the foreseeable effect of hastening their death. Such treatment is, of course, entirely lawful, as it should be, when carried out in good faith and with reasonable care.

Decisions of this kind are made in the ordinary course of the treatment of all patients, having regard to the benefits and burdens of the proposed treatment. As the law recognizes, what those burdens and benefits are varies from patient to patient having regard to all of the circumstances of the case. But in all cases, the intrinsic value of the human life in question is presumed, by the law, to remain. The only criterion the law applies is the benefit to the life in question.

As can be seen, the operation of the law in this way (as with the right to refuse treatment) does not make any assessment that some lives are intrinsically valuable and others are not; to the contrary the law is oriented to the care and dignity of all lives,
recognizing that all human lives have a natural end. This forms the consistent ethos of
the doctor-patient relationship.

Similarly, the “trust” that a patient has in their doctor is one held in them as a doctor,
and not primarily by reason of the personality of the particular doctor. We do not
primarily trust doctors because of their personal qualities (although we, of course, may
to that as well) but because of their profession:

“The professional is presented as trustworthy not primarily in the way a friend is found
to be faithful, by having proved himself or herself in many situations, but by having been
certified as a professional. There is an elegant anonymity to professional trustworthiness;
if I get sick away from home and must go to the emergency room of a hospital, I can in
principle trust doctors and nurses I have never met before. I enter into a fiduciary
relationship with them because they are presented as members of the medical profession,
persons who are certified by the profession and who can, prima facie, be taken as willing to
abide by its norms. I do not have exactly the same kind of trust if my car breaks down
somewhere away from home; I am delivered over rather to the personal honesty,
trustworthiness, and competence of the local mechanic. It is as though I had to find a
temporary friend rather than being able to appeal to a professional.”

It is important, then that if our relationships with doctors are underwritten by a
certification that they abide by certain norms, that the norms that are certified be clear
and consistent. Those norms, at present, even where laws are concerned with the
decisions made toward the end of life, are concerned (and only concerned) with the
“benefit to the life in question” of a particular treatment. The norm involved in
voluntary euthanasia, while it may be expressed in “compassionate” terms, is
nevertheless, a different norm. It is a norm directed to the “relief from the life in
question”. It necessarily takes as its starting point, and its end point, a different ethos.

The difficulty, in maintaining the “good” of our relationship between doctor and
patient is how the norms of “benefit to the life in question” and “relief from the life in
question” can be maintained within the one profession, or indeed, within the one
person. To take Professor Sokolowski’s example as a metaphor, if I get sick away from
home and must go to the emergency room of a hospital, which “norm” has the
anonymous doctor I consult been certified to abide by? For that matter, what norm is to
be followed when I enter any doctor-patient relationship?
Then, finally, we have our relationships with our family and our friends. This is clearly an area where misunderstandings may be rife, so I will confine myself to one (or perhaps two) rhetorical questions.

Clause 6 and 10 of the Bill require that the applicant for euthanasia must sign two separate requests. These requests, explicitly, go to the applicant’s very desire (or lack of desire) to continue living. And yet both clauses prohibit that request being made “in the presence of any near relative”.

We all know why this is so. There is no joy in labouring the point.

Nevertheless we should ask ourselves: What kind of society have we become, and what kind of law are we putting in place, where we have to ensure that at the moment such a profound existential declaration is made, the law requires us to be separated from those closest to us?

In relation to the decision for what other “medical procedure” are we required as a matter of law to exclude our loved ones?

**The Relief of Suffering**

Now I come to the really difficult area and the one in which I know I will be misunderstood. So I will apologise for that misunderstanding in advance and try to muddle through anyway.

I know this because both casual interlocutors and my closest of friends have reduced much of the above discussion to the questions: “So you don’t care about the suffering of others? You would choose to make them suffer?”

It’s powerful and stinging rhetoric. This is so precisely because there are a number of propositions, going to the “goods of human flourishing” that we must recognise (and which the questions imply are being denied), namely:
1. The relief of suffering is a good thing.

2. We should strive to do all that we can to relieve the suffering of others.

How then to recognise the truth of these propositions but respond to the charges made above?

I think the answer is this. The charges presume that the opponent of euthanasia is “choosing” the suffering of the other. Implicit in, and essential to, that proposition is, fundamentally, the proposition that all suffering is a matter of choice.

I want to suggest that this presumption (while beguiling) is not only wrong; it is positively dangerous.

But, first, let me restate: the relief of suffering is a good thing and we should strive to do all that we can to relieve the suffering of others. Nevertheless, there must also be a sense in which we recognise that “suffering” is a constituent part of being human (in the here and now): that, beyond the point at which we can prevent and control suffering, there is a certain measure of suffering that is “given” and not “chosen”. By given I mean: “just there”, as a result of who we are.

To have as our aim “to eliminate suffering”, would therefore, not only be practically (and essentially) impossible but the denial of an aspect of our humanity. Again, I stress, this does not mean we shrug or sigh in the face of human suffering, or adopt a stoic “whatever will be, will be” attitude. It is, however, to recognize that suffering is an irreducible reality in human lives and that to acknowledge it precisely as an irreducible reality is not to choose or will the suffering of others, but to recognize it as something that we must respond to.

I also said that the presumption that all suffering is a matter of choice was positively dangerous. This is because a view that suffering can be eliminated is ultimately a
utopian one, and all utopias tend to end in disaster. They end in disaster precisely because they misunderstand the human condition.

On this point, and in the interests of being completely ecumenical, I call in aid John Gray, Professor of European Thought at the London School of Economics, certainly no theist, in relation to the great utopian projects of the twentieth century:

“Disasters of this magnitude do not come about as a result of ignorance, error or disinformation ... They are consequences of a type of thinking that has lost any sense of reality. Defining a sense of reality is a tricky business, but it is not difficult to know when it is lacking. For the utopian mind the defects of every known society are not signs of flaws in human nature. They are marks of universal repression – which, however, will soon be ended. ... To assess utopian projects as merely flawed exercises in rational policy-making is to miss the point. Such adventures are products of a view of the world, once found only in religious cults and revolutionary sects but for a time firmly established in western governments, that believes political action can bring about an alteration in the human condition.”

The reality of suffering to the human condition is something that will not be eliminated by the passage of the Bill. It will be around long after the Bill (even if passed) is a distant memory.

What, then, are we to do with that reality?

What are we to do with our loved ones, once the doctors have done all that they can and yet the suffering, stubbornly, remains?

Ultimately, we can only do what we have always done (before the option of euthanasia occurred to us).

That is: Be with them.

And anyone who has sat for days next to the hospital bed of a suffering child or visited a relative slowly dying of a terminal illness knows that doing this (that is, doing nothing more than simply being there) hurts. It causes us pain to be in the presence of our loved ones and the pain they are experiencing. A different pain, for sure, but pain
nonetheless. And by that pain, just by being there, in some small way, we share in their suffering.

The Romans have given us a word for that too. We get it by combining the latin for the word “with” (cum) and for the word “suffer” (passus): “to suffer with”.

Compassion.
Parts of this paper have appeared (or are soon to appear) in other forms in Brief Magazine and the University of Notre Dame Law Review.


Which, as Alain Musikanth pointed out to me, is itself a Germanic word (from the word “recht”).

“ius sit objectum iustitiae”, Summa Theologica, II-II, 57, 1.


Tracey Rowland, Culture and the Thomist Tradition, 2003, Rutledge Taylor and Francis Group, at page 152.


Hart, Atheist Delusions (Yale University Press, 2009), page 21-22. Hart goes on, at page 24-25, to contrast this concept of freedom with the “classical” understanding of freedom.


This is so, even if one does not go as far as Robert P George in denying that autonomy is not intrinsically, but only instrumentally, valuable; see MacLeod, “The (contingent) value of autonomy and the reflexivity of (some) basic goods” (2009) J. Juris. 11 at 15.

Consider, for example, Noel Pearson’s observation that:

“The wasteland of responsibility in Indigenous Australia is the consequence of government and bureaucracies and welfare organizations, including NGOs, who have intervened in Aboriginal affairs and said, ‘listen, you don’t have to take responsibility. You have a whole suite of rights, including the right to welfare, the right to drink, the right to party all night, the right to have the trappings of office without being accountable for any return on your role’, “Noel Pearson discusses the issues faced by Indigenous Communities”, ABC, 26 June 2007, www.abc.net.au/lateline/content/2007/s1962844.htm.

One doesn’t necessarily have to agree with Mr Pearson’s conclusion to accept the essential principle that some “rights” are antithetical to human flourishing.

Aristotle, in *The Nicomachean Ethics*, Book VII, Ch ix, uses the word “friendship” (*philia*) in this context, although it is apparent that the concept being employed is what we would refer to as “relationship”.


See Robin Chapple, “Haggling Over Choice” (2009) 36 (11) Brief 32-34 at 33: “It is the most personal act imaginable”.

Clause 6(1) of the *Bill* gives us these criteria:

A person who:

(a) is of sound mind; and  
(b) is aged 21 years or over; and  
(c) is ordinarily resident in Western Australia and has been so ordinarily resident for the previous 3 consecutive years; and  
(d) can communicate his or her intentions; and  
(e) has a terminal illness; and  
(f) is experiencing pain, suffering or debilitation that:  
   (i) is considerable; and  
   (ii) is related to the relevant terminal illness; and  
(g) has no desire to continue living,

may make a request for the administration of euthanasia...”

Clause 9(2) requires two medical practitioners assess a range of matters, including:

“(a) that all of the criteria in subsection 0 apply to the applicant;  
(b) that the applicant’s request is not wholly or substantially referable to, or wholly or substantially a symptom of, a state of clinical depression;  
(c) that the applicant’s request is not wholly or substantially referable to a desire by the applicant to cease to be a burden to family, friends or others;  
(d) that the applicant does not appear to be acting under duress;  
(e) that the applicant has made his or her request:  
   (i) freely and voluntarily; and  
   (ii) with full knowledge of the consequences;  
(f) that the applicant’s request is not the result of external pressure;
(g) that the applicant has consulted with every person with whom he or she reasonably wishes to consult; and

(h) if the applicant’s request was not signed by the applicant, that the applicant is physically unable to sign the request.”

See the definition of “terminal illness” in clause 3 of the Bill.

Remembering that 5 years was the cut-off in the original draft of the Bill.

It should not be assumed that any such person is, by definition, clinically depressed. Such an assertion (apart from being scientifically invalid) is simply to psychologise (or pathologise) all questions of value and transfer to medical professionals, holus bolus, the meaning of all human existence.

To use the language of clause 6(1) of the Voluntary Euthanasia Bill 2009.

My pro-euthanasia friend, Hylton Quail, pulled me up on this line by pointing out that my statement to John and Jane could also be expressed: “It is right and proper and reasonable for you to regard etc etc” and, that the “real objective” judgment being that the lives may not be worth living. I suspect, however, that that still leaves the same problem, but simply removes it to a different level of abstraction. Because, adopting that terminology, the Bill still says to someone else: “No you life is still worth living and you may not regard it otherwise”.

This was essentially the response by Robin Chapple, the author of the Voluntary Euthanasia Bill 2009 to a previous article of mine (see “Haggling Over Choice” (2009) 36 (11 Brief 32-34). The fact that my article was “based on philosophy” appeared to be a point of criticism.


Such treatment would fall within the definition of “palliative care” in section 3 of the Guardianship and Administration Act 1990 (WA), namely a “medical, surgical or nursing procedure directed at relieving a person’s pain, discomfort or distress”. It should be emphasised, however, that “palliative care”, a particular medical sub-speciality, is by no means confined to matters of pain relief: see www.palliativecare.org.au.

And not simply those that meet certain legislative criteria.

This matter was put eloquently by the General Medical Council of the United Kingdom in 2002:

“Life has a natural end, and doctors and others caring for a patient need to recognise that the point may come in the progression of a patient’s condition where death is growing near. In these circumstances doctors should not strive pointlessly to prolong the dying process with no regard to the patient’s wishes, the burden of treatment, or assessments of the effect of treatment on the quality of life remaining for the patient. Instead, an up to date assessment of the benefits, burdens and risks of treatment (or non-treatment) should be made, and the patient’s palliative care needs should be identified and met appropriately.”

