Euthanasia in Western Australia 2010: Background and Analysis

Published in the Chisholm Health Ethics Bulletin Vol. 16 No. 2, Summer 2010

In September 2010, Western Australia’s Legislative Council, the Upper House of that State’s Parliament, voted down a Private Member’s Bill to introduce voluntary euthanasia by a margin of 24 votes to 11. This article reviews the general context and content of the Bill and the public debate on euthanasia before offering more focused analysis.

The Voluntary Euthanasia Bill 2010 was the fourth attempt in fifteen years to introduce euthanasia in Western Australia, and it is unlikely to be the last: the Bill’s sponsor, Hon Robin Chapple MLC (Green), has promised to make another attempt if he is returned at the next State election. Similar bills are already proposed for South Australia, Tasmania, New South Wales and Victoria, and euthanasia is also under discussion in Australia’s Federal Parliament.

In the years since Mr Chapple’s first attempt to introduce voluntary euthanasia in 2002, the legal landscape of end-of-life decision-making in Western Australia has changed considerably. Prompted by controversies surrounding the cases of BWV in Victoria and Terri Schiavo in the USA, WA’s Acts Amendment (Consent to Medical Treatment) Act 2008 created two legal instruments by which a person may exercise some autonomy over the refusal of medical treatments, including life-sustaining treatments, in the event that they are rendered non-competent: binding Advance Health Directives (so-called ‘living wills’) and Enduring Powers of Guardianship (known elsewhere as medical power of attorney). In the view of the pro-euthanasia lobby, however, this Act does not go far enough: it only comes into effect once a patient has been rendered non-competent, and it stops short of permitting the person to request active intervention to end his or her life.

These ‘limitations’ were highlighted in WA in the case of Christian Rossiter, a 49-year-old former stockbroker suffering spastic quadriplegia after a series of spinal injuries. Fed by percutaneous endoscopic gastroscopy (PEG) tube, Mr Rossiter wanted his suffering to end but found himself caught between his legal right to refuse medical treatment on one hand, and his carer’s legal duty to provide the necessities of life on the other. When the WA Supreme Court upheld Mr Rossiter’s right to refuse even his life-sustaining PEG tube, euthanasia supporters predictably decried his inability to seek more active intervention to
end his life. Despite the Chief Justice’s plea, Mr Rossiter became an emblem of an energetic pro-euthanasia campaign in WA, so the fear of lingering suffering and slow painful death continued to echo in public conversation surrounding Mr Chapple’s Bill. (Mr Rossiter subsequently died quite peacefully of natural causes, having refused any treatment for a chest infection but otherwise receiving expert palliative care.)

The WA Legislation

Under the *Voluntary Euthanasia Bill 2010*, persons eligible to make requests for euthanasia had to be of sound mind, aged 21 years or older, a resident of WA for three years, able to communicate, and suffering a terminal illness causing considerable pain, suffering or debilitation. The request for euthanasia had to be made freely and in writing, and witnessed, but not in the presence of any near relative. A medical practitioner to whom such a request was referred, and who agreed to assess it, would have been required to provide the applicant with information concerning the illness, its potential treatments including risks and benefits, the availability of counselling and palliative care, and the methods available to carry out the request. If a second medical practitioner verified that the requirements of the Act had been met, then the applicant could make a second request for euthanasia after the lapse of fourteen days, and euthanasia could then be administered by ‘a recognized drug’. If the applicant at any time gave any indication of revocation, or ceased to be competent or able to communicate, all requests for euthanasia were automatically annulled. Once death had occurred, the medical practitioner was obliged to report it to the Coroner, who was required to make a formal report to the responsible Minister and to Parliament, but was not otherwise required to investigate the death.¹

Although Mr Chapple’s 2010 iteration was more prescriptive than the 2002 version of his Bill, important issues were still left unresolved. Among those of major concern to Parliamentarians were

- the definition of ‘terminal illness’, defined in the Bill as any illness which, ‘in reasonable medical judgment’, will result in death within two years. Members felt this definition was too broad, and too reliant on the doctor’s subjective assessment: sometimes it can be impossible for medical professionals to agree on difficult prognoses.
- lack of definition of ‘pain, suffering or debilitation’: given the subjective nature of ‘suffering’ this provision was thought too broad to be legislated effectively.
• the medical practitioner accepting a euthanasia application needed to have no particular knowledge of palliative care or pain control, or any experience in diagnosing or managing clinical depression, or indeed any specific training in managing the patient’s particular illness.

• the Bill would have required a medical practitioner to make important judgments outside the normal clinical field, for example, whether the applicant was acting under duress or external pressure.

• the requirement to report incidents of euthanasia to the coroner without requiring the coroner to investigate each incident, seemed to some Parliamentarians altogether too arbitrary.

Parliamentarians who opposed the Bill offered broadly similar arguments:

• that euthanasia for pain and suffering is unnecessary given rapid advances in palliative care and pain control;

• that appropriate care decisions are best left to the clinical judgment of medical practitioners;

• that the provision of euthanasia may reduce pressure on the medical community to continue research in palliative care and pain control; and

• that there is no legislative measure able to limit the creep of euthanasia to other classes of non-suffering, non-dying persons.

The last of these objections was quite effective. Data from the Dutch and Belgian experiences were used freely by both sides in the public conversation, as data often are, but Holland’s undeniable creep from ‘voluntary euthanasia’ to ‘non-voluntary euthanasia’ to ‘involuntary euthanasia’ caused great consternation among legislators. It is clear that once euthanasia is permitted for one class of citizens, there are no logical reasons to deny it to other classes of citizens: indeed Holland is currently debating euthanasia for those who are simply ‘tired of living’. This point was made to telling effect by prominent Perth lawyers. Parliamentarians clearly recognized the dangers inherent in attempting to circumscribe by legislation a practice which has proved uncontrollable in other jurisdictions.

Analysis

Opposing sides in the 2010 debate were united on two issues: the need to conduct the public conversation about euthanasia in a spirit of civility and respect, with due attention to
empirical data as far as possible; and the need for all West Australians to have better access to state-of-the-art palliative care. But there were considerable differences in interpretation.

In particular, data generated from the Netherlands were interpreted differently by each side. On close inspection, Dutch Government data over the years are hard to compare longitudinally because study parameters have changed with each iteration, which may go some way to explaining this paradox. From the many meta-analyses of the official data, however, it seems indisputable that legislating for euthanasia has done little to control the self-regulatory practices of Dutch physicians: there are more cases of non-voluntary euthanasia in each study, while as many as one in five cases of euthanasia is not reported at all as Dutch law demands.

Both sides also supported palliative care, but understandings of palliative care differed. In general terms, the pro-euthanasia lobby portrayed palliative care primarily as pain control, which permitted it to highlight the limits of medical knowledge in this regard. Those opposing euthanasia were generally careful not to overstate the capacity of medicine to relieve pain, but more importantly presented a whole-of-life understanding of palliative care: it is about allowing the person to live as well as they can when cure is no longer possible.

As Welsh palliative care specialist Ilora Finlay puts it:

> Modern palliative care is about more than relieving pain and other symptomatic suffering. It seeks to unravel what is causing distress - whether physiological or existential - to empower patients to receive care how and where they wish and generally to restore quality to the last days, weeks, or months of their lives.

It is tempting to interpret these differing views of palliative care as nothing more than an echo of divergent views among the medical professions, but as the WA debate progressed a more disturbing truth gradually emerged: those driving the campaign for euthanasia were far less interested in pain control and palliative care than they were in promoting personal autonomy. Baroness Finlay again:

> It is ironic that almost simultaneously with improvements in care for the dying, there has been a rise in the volume and stridency of calls for the legalization of euthanasia. The explanation lies in the arguments now being put forward by pro-euthanasia campaigners. Their arguments no longer focus on relief of terminal suffering but rather on the promotion of personal choice and control. . . . In a recent pamphlet Dignity in Dying [formerly the Voluntary Euthanasia Society]
stated that ‘no amount of good palliative care can address some patients’ concerns regarding their loss of autonomy, loss of dignity and loss of control.’

Perhaps this explains why the pro-euthanasia case is so difficult to counter in public debate. What seems at first a conversation about medicine and necessary pain control is in fact a conversation about autonomy and personal preference - it has nothing to do with medicine or symptom relief or palliative care at all. But as the argument for legalizing euthanasia has shifted from physical pain and suffering at the end of life to autonomy and existential suffering in much broader terms, the ‘pain-and-suffering’ language used by pro-euthanasia campaigners has not changed. This makes it easy for campaigners to whip up emotive support for legislative reform while their real goal lies elsewhere.

This hidden agenda for euthanasia law reform explains the ‘bracket creep’ evident in the Netherlands, where after years of legal euthanasia the public conversation is now about the rights of those who are simply ‘tired of living’. So too the WA Euthanasia Society’s use of Christian Rossiter only while it suited their cause. The dangerous consequences of such an impersonal and unbalanced notion of autonomy, which are explored elsewhere, cannot be overestimated.

Fortunately, a majority of WA’s Legislative Council saw through this ploy and defeated Mr Chapple’s voluntary euthanasia Bill. Future attempts to introduce euthanasia will hang not only on who communicates best with legislators at that time, but also and ultimately on our ability to resist the ‘unbalanced autonomy’ argument on one hand, and our success in improving access to excellent palliative care on the other.

1 For the WA Voluntary Euthanasia Bill 2010 as well as previous WA euthanasia bills, see Parliament of Western Australia, http://www.parliament.wa.gov.au/web/newwebparl.nsf/iframewebpages/Bills+-+All
2 See, for example, Cristina Odone, Assisted Suicide: How the chattering classes have got it wrong. (London: Centre for Policy Studies, 2010), http://www.scribd.com/doc/39694762/Assisted-Suicide-How-the-chattering-classes-have-got-it-wrong
9 Ibid, 1840.
Ibid, 1841: “There is evidence from countries that have gone down the ‘assisted dying’ road that, once the campaigners achieve one goal, they simply move on to the next in an attempt to widen the goalposts further.”

Ibid, 1841: “The uncritical use of such language, however, makes it easy to stir up public sympathy for legislative change. The case for legalization has shifted to existential suffering but the language being used to justify it has not moved on.”

See Odone, also Joseph Parkinson, *Over the Edge: Individual Autonomy and Flat-Earth Ethics*, (Curtin University Annual Ethics Lecture 2009).


Rev Dr Joseph Parkinson STL PhD is the Director of the L J Goody Bioethics Centre in Perth.

All on-line resources accessed 5 November 2010.

*Joseph Parkinson*