Archbishop Costelloe reflects on Voluntary Euthanasia

THE RECENT tragic deaths of an elderly Albany couple again raises the issue of voluntary euthanasia. Federal members Alannah MacTiernan and Richard Di Natale now seek cross-party support for a private member's Bill to legalise voluntary euthanasia nationally.

As human beings we are, by our very nature, oriented to others. From conception and beyond birth we are intimately connected to, and dependent on, others. As we grow and develop, so too the web of our relationships grows more intricate with others also depending on us. While we may strive to establish our own independence, the really happy people are those whose well-being, value and purpose lie in the life-giving relationships that develop over time.

It is within relationships that we come to see that the decisions we make, even deeply personal ones, impact on others. They affect those closest to us while also having a wider impact, affecting the entire human race of which we are each but one part.

This raises a key issue in the euthanasia debate. Decisions individuals may make about determining the time and manner of their death have implications beyond their own lives. Once the right to end one's life is written in law, the absolute inviolability of human life is relativized. It then becomes possible to ask if and under what circumstances others might have the right, or even the obligation, to end another person's life. Worse still, individuals may feel not only the right but even the duty to end their own lives.

This is the slippery slope argument, dismissed by some as a scare-tactic. To counter this, some suggest enshrining suitable safeguards in legislation: require the agreement of two medical professionals; restrict euthanasia to those terminally ill; require informed consent; have a cooling-off period before the person is assisted to end their life; specifically legislate so that no changes can be introduced to the legislation; and so on.

Even with good intentions of legislators, there is no way of ensuring that future governments will not change legislation should they have the required number of parliamentary members to do so. The experience of other countries reveals this.

Belgium introduced voluntary euthanasia in 2002. Earlier this year, merely twelve years later, euthanasia is now permissible not only for the terminally ill but for those experiencing unbearable suffering. Terminally ill children of any age can also request euthanasia (the Netherlands sets the age at 12 years) as long as they are capable of discernment, attested to by psychologists, and with their parents' approval.

Considering these developments, it is not scare-mongering to ask if future legislation might include severely physically disabled people, those suffering distressing and degenerative neural conditions such as dementia, and infants whose medical conditions are incurable, though not life-threatening.

Although those calling for legalised euthanasia across Australia may reject the extreme examples cited, once the fundamental principle of the inviolability of human life is breached, no firm guarantee can be given against any future breaches.

In some jurisdictions active participation by medical personnel is required to administer euthanasia. Presumably, under any proposals put to the Federal Parliament medical professionals will be able to conscientiously object and not be required by law to assist in such procedures. But how confident can we be?

Abortion law reform in Victoria demands that doctors who conscientiously object to abortions are required by law to refer patients requesting abortions to another doctor who will agree to this procedure. Their legal right not to be complicit in something they find morally objectionable no longer exists.

Although proponents of voluntary euthanasia suggest otherwise, many people do not seem to understand the difference between active euthanasia and care for the terminally ill and dying. Once a person has entered into the dying process, burdensome or therapeutically futile medical treatments are often legitimately withdrawn. When pain is severe, strong medications can be administered to bring relief, with the secondary effect of shortening a person's life. This is not active euthanasia but good medical care. Its aim is not to kill but to make the person comfortable, enabling them to die with dignity and, where possible, serenity.

What we need is not more legislation but to extend the provision of palliative care services and facilities to help support both the dying and their loved ones. This support needs to be medical, psychological, spiritual and practical, readily available and affordable and above all holistic. All of us - governments, churches, institutions, families, individuals - must accept this responsibility. If we don't, then we all become vulnerable to the influence of those with the loudest voices or more immediate access to power.

It is for this reason the Church stands firmly against voluntary euthanasia believing that respect for human life, from conception to natural death, is a fundamental pillar of what it means to be human. No-one has the right to take the life of an innocent person. Neither do we have the right to take our own lives.

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