BIOETHICS NEWSLETTER

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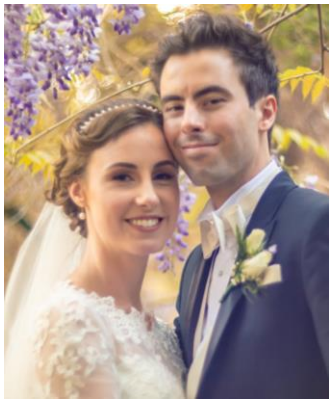
IN THIS ISSUE

WELCOME TO 2020!



Thank you for the nomination and election to be the CWL Bioethics Convener. I would like to take this opportunity to introduce myself. My name is Helenka Mannering. This past year was a big and busy year for me. In October, I was married and have now begun settling into my new role as a wife. I also started my PhD at the beginning of 2019. The fields I am most interested in are moral theology and anthropology, as well as theology and culture. I am studying at the Catholic Institute of Sydney.

Prior to studying at CIS, I completed a Master of Sacred Theology degree at the John Paul II Institute in Melbourne, and a Bachelor of Arts degree at the Australian Catholic University and at Aquinas College, Nashville Tennessee.

For work, I have been lecturing at the University of Notre Dame in their Core Curriculum (Logos) program. This program is compulsory for undergraduate students and provides a good opportunity to introduce them to the fundamentals of philosophy, ethics, and Catholic theology. However, in February I will be leaving this role and moving with my husband to Wagga Wagga.

I am looking forward to publishing bioethics newsletters for the CWL as often as I can. Dr Deidre Little certainly left big shoes to fill, and I am aware of my lack of expertise or experience in the field in comparison. However, I will do my best and hope to provide material that will be both interesting and useful to read. I also welcome any comments or suggestions which you may have: my email is helenka.mannering@gmail.com

Apart from providing commentary on the most pertinent bioethical issues facing Australia currently, I will also include sections on Catholic bioethical principles. I hope these tools will assist with evaluating challenges in the future, as well and providing a deeper understanding regarding the reasoning behind Church teachings which are perceived to be controversial.

I wish you all a grace-filled Christmas season, and a joyous new year.

Helenka

IN DEPTH: END OF LIFE ISSUES

On the 12th of December 2019, Western Australia became the second Australian state and the nineteenth jurisdiction in the world to legalise Voluntary Assisted Dying (henceforth VAD)/ euthanasia. These laws, which are expected to come into effect in about 18 months' time, have been labelled as "Australia's most liberal voluntary assisted dying laws."[1] They bear some significant differences from the Victorian VAD legislation, which was approved in November 2017 and came into effect on the 19th of June 2019. First, the Victorian legislation only permits self-administration of the lethal substance, although it makes a provision that a medical professional can administer it, but only if the patient is unable to do so.[2] In contrast, the WA legislation permits the poison to be either self-administered or physician/nurse practitioner administered.[3] Second, in Victoria, a psychiatrist must be consulted to determine whether the requesting patient has any underlying illnesses impairing their judgement, whereas this is not required under the WA legislation.[4] Although an amendment was proposed that this be required in WA, the amendment was not passed.[5] Third, the Victorian law requires a specialist to assess the patient's medical condition, which is once again not the case with the WA law. In WA, in theory, a general practitioner could be consulted by a patient suffering from pancreatic cancer and make the judgement that the patient will likely die from the disease within six months, even though he or she may have not had much previous experience treating pancreatic cancer.[6]

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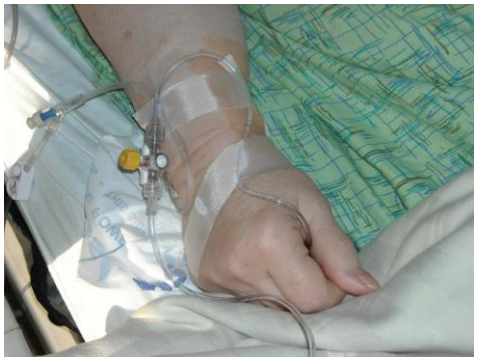
The substances which are used for VAD remain problematic. In Victoria, the exact substances which are used have not been disclosed "to minimise the risk to the public."[7] However, the public has been reassured that the rumours that the illegal drug pentobarbital (also known as Nembutal), which is commonly used for euthanasia overseas, will be used are false. Professor Michael Dooley, the pharmacy director of the Alfred Hospital,[8] stated that the drugs that are used in Victoria are legal, and that they would be different depending on whether the patient was going to swallow or inject them.[9] Given the consequential amendments made following the *Voluntary Assisted Dying Act 2017*, particularly the amendments to the *Drugs, Poisons and Controlled Substances Act 1981*, it is likely that the substances used in Victoria are either Schedule 9 poisons, Schedule 8 poisons, or Schedule 4 poisons.[10] Schedule 9 poisons are prohibited substances and therefore unlikely to be used. The WA legislation states that the VAD substances to be used in that jurisdiction are Schedule 4 poisons or Schedule 8 poisons.[11] However, in relation to these substances, Labor MP Adele Farina claimed that they are experimental in nature and do not guarantee a humane death.[12] This is supported by research, such as the article titled "Legal and ethical implications of defining an optimum means of achieving unconsciousness in assisted dying," which appeared in the medical journal *Anaesthesia* in 2019.[13] The authors of this article, while not opposed to assisted dying, found



that the two methods commonly used in VAD, which employ both Schedule 4 and Schedule 8 poisons, have significant legislations. These two methods are:

1. Self-administered barbiturate ingestion to achieve unconsciousness which also leads to cardiorespiratory collapse and asphyxia (and similar methods)[14]
2. Physician administered anaesthetic or other i.v. drug, followed by a neuromuscular blocking drug[15]

Both these methods have contributed to high rates of reported complications where VAD is legal, anywhere between 5 to 17 percent, including "regurgitation, seizures, failure to be fully unconscious before asphyxiation or heart attack occurs, lengthy time from ingestion to death, and failure to die."[16] It is important to keep in mind that adequate reporting procedures are not in place in many of the jurisdictions where VAD is legalised, so it is possible that these numbers are much higher.

The first approach, sometimes referred to as 'passive participation,' has the following data. After oral ingestion of the sedative, patients usually lose consciousness within five minutes. However, Sinmyee et. al. write:

> Cardiopulmonary collapse occurs within 90 min in two-thirds of cases, in a third of cases death can take up to 30 h.[17] Other complications include difficulty in swallowing the prescribed dose (in up to 9%) and vomiting thereafter (in up to 10%), both of which prevent suitable dosing, and re-emergence from coma (in up to 2%)."[18]

These outcomes demonstrate the radical inadequacy of this method as currently administered. It is important to keep in mind that this is the primary method legislated for by the Victorian Act, as well as one of the methods in the WA Bill.

The second approach, sometimes referred to as 'active participation,' is allowed under the WA Bill but restricted under the Victorian Act to situations where the patient is unable to self-administer the substance. This method, too, presents serious limitations. For example, it is very difficult to monitor whether the patient is indeed unconscious once the anaesthetic has been administered, particularly in the presence of a neuromuscular blockade. In their article referred to above, Sinmyee et. al. turned to research surrounding capital punishment in the USA, where similar drugs to those used in 'active participation' euthanasia are administered during executions. They found that there were numerous recorded instances of prisoners being awake during executions, with the drug administered to render them unconscious proving ineffective. They concluded that:

> The literature concerning US capital punishment indicates that although similar agents are used as during clinical anaesthesia, conduct in their administration falls well short of being able to satisfy the requirement of achieving unconsciousness at the point of death. Expressed another way, the lesson from these unfortunate experiences is that any optimum method used to achieve unconsciousness in voluntary assisted dying must be tangibly different from, and superior to, all the methods currently used in capital punishment.[19]

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However, from the data available from jurisdictions where VAD is legal, it has been found that outcomes do not differ much from those reported in the US under capital punishment. Complications with 'active participation' VAD/euthanasia included "difficulties with intravenous access which preclude proceeding (3%); prolonged time to death (up to 7 days from drug administration in up to 4%); and failure to induce coma (with patients re-awakening, even sitting up, in up to 1.3%), and are more common in those who are not frail."[20]

There are other concerns regarding the WA legislation, which look at it from a practical/ethical perspective, not a faith-based perspective, include that a witness is not required to be present when the poison is taken, that there is no way of reporting adverse outcomes if such occur, and that there is no way of determining whether the person is taking the poison voluntarily. Furthermore, given that elder abuse is a significant problem within our society, there aren't sufficient safeguards against this occurring and influencing a patient's decision to request VAD. As the Hon. Nick Goiran MLC, Shadow Minister for Child Protection; Prevention of Family and Domestic Violence, stated in a speech to the WA Parliament:

> If we are intellectually honest and reason through the theory of a euthanasia regime, we should conclude that it is inherently unsafe. The insufficiency of the criminal justice safeguards inform us of this. The prevalence of medical negligence informs us of this. The ease of doctor shopping informs us of this. The existence of elder abuse informs us of this, and the reality of doctor bias informs us of this.
>
> There is a safe approach to end-of-life choices; however, it will require all of us to persistently insist that quality palliative care is made available to every Western Australian and until we… have exhausted ourselves in fulfilling this duty, we should not contemplate a euthanasia regime, let alone this bill, which is more dangerous than the Victorian legislation and more dangerous than the now inoperative Northern Territory legislation.[21]

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What is the status of other Australian state regarding the legalisation of VAD? In NSW, the Voluntary Euthanasia Party has recently merged with the NSW branch of the Reason Party (formerly known as the Sex Party) in order to present a stronger push for assisted dying laws in NSW.[22] Assisted Dying Laws failed to pass NSW parliament by one vote in 2017.[23] Other priorities of the Reason Party include "drug reform, access to medical cannabis and co-ordinating a state-led revolt against the federal religious freedom legislation."[24] In Queensland and South Australia, inquiries into the issue are due to report in 2020. In Tasmania, the pro-VAD group "Dying with Dignity" is seeking support from MPs and encouraging the development of a private members bill. The Territories are required to enact Federal Legislation on this matter.

One common argument against VAD/Euthanasia is the slippery slope, namely, that there will be an incremental extension in the practice of assisted suicide. Some may claim that it is not conclusive nor sufficiently demonstrative, however, given the data we have from jurisdictions where VAD has been legal for decades, it is reasonable to conclude that a slippery slope is likely. Case studies include the Netherlands, Belgium, Switzerland, Canada, and Oregon. Euthanasia was legalised in the Netherlands in 1973 and was originally restricted only to adults. In 2001, legislation was extended to include children over 12 requesting euthanasia with parental consent, and then in 2005 this was further extended to include younger children, including newborns. The expansion of eligibility and accessibility of euthanasia in the Netherlands has resulted in the following startling statistics: "The most recent data indicate that, in the Netherlands, 58% of all deaths now involve an end-of-life decision; ~18% involve physician-prescribed continuous deep sedation and ~5% involve physician-assisted suicide or euthanasia."[25] One trend that has been noted in the Netherlands is what is referred to as 'doctor shopping': seeking out doctors which will easily agree to euthanasia even when others questions the patient's eligibility.[26] A number of cases have emerged which reflect unlawful processes, including: a physician failing to accurately diagnose the patient's back pain in 2011 (as found by the Regional Euthanasia Review Committee), two cases of patients with dementia not handled with due care in 2012, the assisted suicide of a woman with chronic depression in 2014, and euthanasia carried out in 2015 on a woman with a history of stomach pains with an undiagnosed cause. As Goiran concludes, "The experience observed of assisted suicide in the Netherlands demonstrates an incremental extension in the practice of assisted suicide, the commercialisation of doctor shopping, and the reality that no redress is available when safeguards inevitably fail."[27] Trends in Belgium, Switzerland, Canada, and Oregon show similar movements.[28] Even the Victorian model has already been "heavily criticised by proponents of assisted suicide, with calls to extend the scope… made before the law has even come into force."[29]

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The Catholic Perspective

> *Life is a gift of God, and on the other hand death is unavoidable; it is necessary, therefore, that we, without in any way hastening the hour of death, should be able to accept it with full responsibility and dignity. It is true that death marks the end of our earthly existence, but at the same time it opens the door to immortal life.*[30]

Our faith offers us a deeper insight into the reality of things and enables us to evaluate with greater clarity issues which may seem unclear through the use of reason alone, or due to the involvement of strong emotions. On the topic of euthanasia, some of the most relevant documents include:

1. John Paul II, *Evangelium Vitae: Encyclical Letter on the Value and Inviolability of Human Life*, 1995
2. Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, 1980
3. Catechism of the Catholic Church, especially sections 2276-2279

It is important to recognise that when the Church speaks of euthanasia, she is referring to what in current legislation is referred to as Voluntary Assisted Dying, namely, "an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering."[31] This can be either self-administered or physician administered, but what sets it apart from other palliative treatments is the intention behind the act (to cause death) and the methods used.[32]

This necessitates the recognition of some important distinctions when it comes to euthanasia and other palliative treatments. First, patients, medical practitioners and palliative care providers are not required to prolong life at all costs.[33] The Church here makes a distinction between proportionate and disproportionate means of treatment (a distinction which used to be referred to as ordinary versus extraordinary means).[34] 'Ordinary' or 'proportionate' means are "all interventions that offer reasonable hope of benefit for the patient and can be obtained and used without excessive expense, pain, or other inconvenience."[35] Extraordinary, or disproportionate, means are, on the contrary, are "all interventions that cannot be obtained or used without excessive expense, pain, or other inconvenience for the patient or for others or which, if used, would not offer reasonable hope of benefit for the patient."[36] To refuse to undergo disproportionate treatment does not equate to euthanasia or suicide: rather, such a refusal should be understood as "acceptance of the human condition in the face of death."[37]

Furthermore, there is a distinction between the use of pain relief or sedation with the intention of alleviating symptoms, even if death is hastened as a result, and the use of pain relief or sedation with the intention of causing death.[38] To better understand this, it is helpful to briefly digress to introduce the principle of double effect. The principle of double effect is method of evaluating the morality of certain complex issues which has been commonly used within the Catholic moral tradition. It states that an action which has both good and bad consequences, may be morally permissible, if all four of the following conditions are met:

1. The act-in-itself must not be morally wrong.
2. The bad effect must not cause the good effect.
3. The agent must not intend the bad effect.
4. The bad effect must not outweigh the good effect[39]

Using this principle as an assistance to discerning morality, we can draw the following conclusions. VAD/euthanasia can be interpreted as failing to meet all four conditions: the first, because the act-in-itself consists in ingesting poison or injecting poison; the second, because the bad effect (death) causes the good effect (alleviation of suffering); the third, because the bad effect (death) is directly intended; and the fourth, because the bad effect (death) outweighs the good effect (alleviation of suffering). On the other hand, the use of pain relief with the intention of alleviating symptoms, even if death is hastened as a result, may be permissible, because (1) the act-in-itself (using pain relief) is not morally wrong; (2) the bad effect (hastening death) does not cause the good effect (pain relief); (3) the bad effect (hastening death) is not directly intended. The fourth condition would have to be evaluated on a case-by-case basis but may be met if death is imminent. Therefore, it is possible to conclude, according to the Catechism:

> Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable.[40]

Another question which has been posed regarding end-of-life issues is the morality of sedation at the end of life. Pope Pius XII already faced this question in 1956. To the question "Is the suppression of pain and consciousness by the use of narcotics… permitted by religion and morality to the doctor and the patient (even at the approach of death and if one foresees that the use of narcotics will shorten life)?," Pope Pius XII responded "If no other means exist, and if, in the given circumstances, this does not prevent the carrying out of other religious and moral duties: Yes."[41] Here, once again, we can discern the principle of double effect in use, for it is not the bad effect which is directly being intended, nor is the bad effect the means for achieving the good effect. Therefore, the Congregation for the Doctrine of the Faith states,

> In this case, of course, death is in no way intended or sought, even if the risk of it is reasonably taken; the intention is simply to relieve pain effectively, using for this purpose painkillers available to medicine. However, painkillers that cause unconsciousness need special consideration. For a person not only has to be able to satisfy his or her moral duties and family obligations; he or she also has to prepare himself or herself with full consciousness for meeting Christ."[42]

Our Catholic faith gives us a broader perspective on the meaning of life and death. For us, death is not merely the end, but a gateway into a new life. As Benedict Faneye writes, "according to the Christian view of what

constitutes the goal of life, the decision to choose a treatment as a means for preserving life or forgoing it may actually be measured by the desire to have eternal life with God."[43] We are enabled to see things in perspective of eternal life and the coming resurrection of the body, recognising that this painful separation of soul and body is not an eternal sentence.[44] We are also able to unite our death with the death of Christ, entrusting ourselves to God's mercy, and understanding that Christ has given a new, redemptive, meaning to existence and to death: as St. Paul says "If we live, we live to the Lord, and if we die, we die to the Lord" (Rom. 148; cf. Phil. 1:20). At the same time, we recognise that God is the master of life and death, and that life is a gift from God. Nicholas Tonti-Filippini writes, "We are obliged to accept life gratefully and preserve it for his honour and the salvation of our souls. We are stewards, not owners, of the life God has entrusted to us. It is not ours to dispose of."[45]

Suffering, particularly suffering at the end of life, can be a trial and test of all the virtues, and a preparation for eternal life. It enables us to face up to the weakness of the human condition, and recognise our radical and total dependence on God, our loving Father and Creator

Our faith brings meaning not only to death, but also to suffering.[46] Suffering, particularly suffering at the end of life, can be a trial and test of all the virtues, and a preparation for eternal life. It enables us to face up to the weakness of the human condition, and recognise our radical and total dependence on God, our loving Father and Creator. The Congregation for the Doctrine of the Faith writes, "according to Christian teaching… suffering, especially suffering during the last moments of life, has a special place in God's saving plan; it is in fact a sharing in Christ's passion and a union with the redeeming sacrifice which He offered in obedience to the Father's will."[47]

To conclude, I would like to invite you to say a prayer to Mary, who stood beside her Son as he suffered in anguish on the Cross. She provides us with an example to follow to accompany those who are nearing the end of their earthly pilgrimage, and to provide spiritual support in the most challenging moments of life. This prayer is taken from John Paul II's encyclical *Evangelium Vitae*:

O Mary,
bright dawn of the new world,
Mother of the living,
to you do we entrust the cause of life
Look down, O Mother,
upon the vast numbers
of babies not allowed to be born,
of the poor whose lives are made difficult,
of men and women
who are victims of brutal violence,
of the elderly and the sick killed
by indifference or out of misguided mercy.

Grant that all who believe in your Son
may proclaim the Gospel of life
with honesty and love
to the people of our time.

Obtain for them the grace
to accept that Gospel
as a gift ever new,
the joy of celebrating it with gratitude
throughout their lives
and the courage to bear witness to it
resolutely, in order to build,
together with all people of good will,
the civilization of truth and love,
to the praise and glory of God,
the Creator and lover of life.[48]

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[1] Paige Taylor, "WA to Bring in Assisted Dying Law," *The Australian* 2019.
[2] The Victorian Act reads, "A practitioner administration permit in respect of a person specified in the permit authorises the co-ordinating medical practitioner for the person, for the purpose of causing the person's death – (a) to prescribe and supply to the person a sufficient dose of the voluntary assisted dying substance specified in the permit; and (b) in the presence of a witness receive an administration request; and (c) to possess, use, and administer in the presence of a witness, the voluntary assisted dying substance to the person if – (i) the person is physically incapable of the self-administration or digestion of the voluntary assisted dying substance…" Parliament of Victoria, *Voluntary Assisted Dying Act 2017*, 61, p.40.
[3] The Bill reads, "(1) The patient may, in consultation with and on the advice of the coordinating practitioner for the patient – (a) decide to self-administer a voluntary assisted dying substance (a ***self-administration decision***); or (b) decide that a voluntary assisted dying substance is to be administered to the patient by the administering practitioner for the patient (a ***practitioner administration decision***)." Parliament of Western Australia, *Voluntary Assisted Dying Bill 2019*, 139, p.39. Emphasis original.
[4] It is important to note, however, that it has been found that a single psychiatric visit is "inadequate to determine whether a psychiatric disorder is impairing the judgement of a patient seeking assisted suicide." Nick Goiran, "The Safe Approach to End of Life Choices: License to Care Not Licence to Kill: Minority Report by Hon N.P. Goiran Mlc for the Joint Select Committee on End of Life Choices Submitted under Legislative Assembly Standing Order 274," (Parliament of Western Australia, 23 August 2018), xii.
[5] Richard Egan, "Another Australian State on the Verge of Legalising Euthanasia," *Mercatornet* 9 December 2019.
[6] One of the clauses of the Bill states that an eligible person must be diagnosed with "at least 1 disease, illness or medical condition that – (i) is advanced, progressive and will cause death; and (ii) will, on the balance of probabilities, cause death within a period of 6 months or, in the case of a disease, illness or medical condition that is neurodegenerative, within a period of 12 months; and (iii) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable." Parliament of Western Australia, *Voluntary Assisted Dying Bill 2019*, p.14.
[7] Hall and Wilcox report, "To minimise the risk to the public the exact composition of the voluntary assisted dying substance is unavailable. In addition, the appropriate medications will vary on a case by case basis depending on the individual person and their medical condition. Access to this substance is provided free of charge to the persons seeking to use the medication." "Voluntary Assisted Dying Laws Commence in Victoria - Voluntary Assisted Dying Act 2017 (Vic)," *Hall and* Wilcox, 19 June 2019, https://hallandwilcox.com.au/thinking/voluntary-assisted-dying-laws-commence-in-victoria-voluntary-assisted-dying-act-2017-vic/.
[8] The Alfred has been appointed as the sole importer, preparer, and supplier of the lethal substances.
[9] Aisha Dow, "Lethal Medication Sourced for Victoria's Voluntary Euthanasia Scheme," *The Age* 4 January 2019.
[10] Parliament of Victoria, *Voluntary Assisted Dying Act 2017*, p.92
[11] "The CEO may, in writing, approve a Schedule 4 poison or Schedule 8 poison (as those terms are defined in the *Medicines and Poisons Act 2014* section 3) for use under this Act for the purpose of causing a patient's death." Parliament of Western Australia, *Voluntary Assisted Dying Bill 2019*, p.9.
[12] Egan, "Another Australian State on the Verge of Legalising Euthanasia."
[13] S. Sinmyee, V.J. Pandit, J.M. Pascual, A. Dahan, T. Heidegger, G. Kreienbuhl, D.A. Lubarsky, J.J. Pandit, "Legal and Ethical Implications of Defining an Optimum Means of Achieving Unconsciousness in Assisted Dying," *Anaesthesia* 74 (2019).
[14] Ibid., 631.
[15] Ibid., 631-2.
[16] Egan, "Another Australian State on the Verge of Legalising Euthanasia."
[17] Cf. K.V. Iserson, D.R. Gregory, K. Christensen, M.R. Ofstein, "Willful Death and Painful Decisions: A Failed Assisted Suicide," *Cambridge Quarterly of Healthcare Ethics* 1 (1992). B.D. Groenewoud, A. van der Heide, J.H. Onwuteaka-Philipsen, D.L. Willems, P.J. van der Maas, G. van der Wal, "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands," *New England Journal of Medicine* 342, no. 551-6 (2000). A. Lalmohamed, A. Horikx, "[Experience with Euthanasia since 2007. Analysis of Problems with Execution]. [Article in Dutch]." *Nederlands Tijschrift Voor Geneeskunde* 154, no. A1882 (2010).
[18] S. Sinmyee, "Legal and Ethical Implications of Defining an Optimum Means of Achieving Unconsciousness in Assisted Dying," 633. Sinmyee et. al. also state "It is striking, that the incidence of 'failure of unconsciousness' is approximately 190 times higher when it is intended that the patient is unconscious at the time of death, as when it is intended they later awaken and recover after surgery (when accidental awareness is approximately 1:19,000)." Ibid.
[19] Ibid., 632-3.
[20] Ibid., 633.
[21] Nick Goiran, 2019, *Voluntary Assisted Dying Bill 2019*, https://www.nickgoiran.com.au/articles.
[22] Caitlin Fitzsimmons, "'New Voices': Reason Party Comes to Nsw to Revive Push for Assisted Dying Laws," *The Sydney Morning Herald* 29 December 2019.
[23] Sean Nicholls, "Voluntary Assisted Dying Bill Defeated in Nsw Upper House," ibid. 16 November 2017.
[24] Fitzsimmons, "'New Voices': Reason Party Comes to Nsw to Revive Push for Assisted Dying Laws."
[25] S. Sinmyee, "Legal and Ethical Implications of Defining an Optimum Means of Achieving Unconsciousness in Assisted Dying," 631. Cf. A. van der Heide, J.J.M. van Delden, B.D. Onwuteaka-Philipsen, "End-of-Life Decisions in the Netherlands over 25 Years," *New England Journal of Medicine* 337 (2017).
[26] "Consistent with the Northern Territory experience, assisted suicide in the Netherlands takes place notwithstanding disagreement amongst physicians about patient eligibility." Goiran, "The Safe Approach to End of Life Choices: License to Care Not Licence to Kill: Minority Report by Hon N.P. Goiran Mlc for the Joint Select Committee on End of Life Choices Submitted under Legislative Assembly Standing Order 274," xix. Furthermore, Gioran found that "Doctor shopping in the Netherlands has now become commercialised by the emergence of at least one private organisation who will provide assisted suicide to patients whose own physician has declined." Ibid.
[27] Ibid., xx.
[28] Cf. Ibid.
[29] Ibid., xxv.

[30] Congregation for the Doctrine of the Faith (henceforth CDF), *Declaration on Euthanasia*, 1980, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html.
[31] John Paul II, *Evangelium Vitae: Encyclical Letter on the Value and Inviolability of Human Life,* 1995, http://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html. S.65. See also Faith Declaration on Euthanasia. Introduction.
[32] CDF, *Declaration on Euthanasia*.
[33] Nicholas Tonti-Filippini, *About Bioethics: Caring for People Who Are Sick or Dying*, vol. 2 (Ballan VIC: Connor Court, 2012), 72.
[34] CDF, *Declaration on Euthanasia,* IV.
[35] Tonti-Filippini, *About Bioethics: Caring for People Who Are Sick or Dying*, 2, 74.
[36] Ibid. It should be noted that the distinction between proportionate and disproportionate means is a moral, not a medical, distinction. This means that "it is the individual patient alone and not the physician who can make the determination on what treatment constitutes ordinary or extraordinary means." Benedict Faneye, "The Euthanasia Debate: Importance of Spiritual Care in End of Life," *Philosophy Study* 9, no. 12 (December 2019): 718.Cf. B. M. Ashley and K. D. O'Rourke, *Ethics of Health Care: An Introductory Textbook*, 2nd ed. (Washington DC: Georgetown University Press, 1994).
[37] John Paul II, *Evangelium Vitae: Encyclical Letter on the Value and Inviolability of Human Life,* 65. John Paul II writes, "Euthanasia must be distinguished from the decision to forego so-called 'aggressive medical treatment,' in other words, medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family. In such situations, when death is clearly imminent and inevitable, one can in conscience 'refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted.' Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the means of treatment available are objectively proportionate to the prospects for improvement." Ibid, 65. Similarly, the Catechism states, "Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of 'over-zealous' treatment." *Catechism of the Catholic Church*, (Homebush NSW: St Pauls, 1994), 2278.
[38] As William Sullivan and John Heng state, "there is a clear ethical distinction between euthanasia, which always involves the intention to suppress consciousness as a means to hastening death, and the appropriate use of sedatives to relieve or manage symptoms and distress." William Sullivan and John Heng, *Bioethics Outlook* 24, no. 2 (2013): 5.
[39] D. F. Kelly, *Contemporary Catholic Health Care Ethics* (Washington DC: Georgetown University Press, 2004).
[40] *Catechism of the Catholic Church*, 2279.
[41] The passage, in French, reads: En résumé, vous Nous demandez : « La suppression de la douleur et de la conscience par le moyen des narcotiques (lorsqu'elle est réclamée par une indication médicale), est-elle permise par la religion et la morale au médecin et au patient (même à l'approche de la mort et si l'on prévoit que l'emploi des narcotiques abrègera la vie) ? ». Il faudra répondre : « S'il n'existe pas d'autres moyens et si, dans les circonstances données, cela n'empêche pas l'accomplissement d'autres devoirs religieux et moraux : Oui ». Pius XII, *Discours du Pape Pie XII en reponse a trois questions religiouses et morales concernant l'analgesie, 1956*, http://www.vatican.va/content/pius-xii/fr/speeches/1957/documents/hf_p-xii_spe_19570224_anestesiologia.html.
[42] CDF, *Declaration on* Euthanasia, III. According to the 2011 'consensus statement' of the International Association of Catholic Bioethicists, the sedatives which are most often used in palliative care as a "means to care for persons who are experiencing severe and intolerable symptoms and distress" include: "Opiates (e.g. morphine, oxycodone and hydromorphone), which are used in palliative care to manage pain and other symptoms, can have a sedative effect but should not be used primarily for their sedative properties. The most common classes of medications used in palliative care for their sedative properties are psychotropic medications such as benzodiazepines (e.g., Midazolam and Lorazepam), barbiturates (e.g., Phenobarbital), antipsychotic medications (e.g., Chlorpromazine and Haloperidol), and increasingly, anesthetic agents such as Propofol, Dexmedetomidine, and Ketamine." International Association of Catholic Bioethicists, "The Use of Sedatives in the Care of Persons Who Are Seriously Ill or Dyine: Ethical Distinctions and Practical Recommendations," *Bioethics Outlook* 24, no. 2 (2013): 7.
[43] Faneye, "The Euthanasia Debate: Importance of Spiritual Care in End of Life," 719. Cf. B. M. Ashley and K. D. O'Rourke, *Ethics of Health: A Theological Analysis*, 4th ed. (Washington DC: Georgetown University Press, 1997).
[44] Nicholas Tonti-Filippini writes, "The belief in resurrection humanises the dying process by giving us hope." Tonti-Filippini, *About Bioethics: Caring for People Who Are Sick or Dying*, 2, 71.
[45] Ibid., 72-3. The Catechism of the Catholic Church states, Catechism: "Everyone is responsible for his life before God who has given it to him. It is God who remains the sovereign Master of life. We are obliged to accept life gratefully and preserve it for his honor and the salvation of our souls. We are stewards, not owners, of the life God has entrusted to us. It is not ours to dispose of." *Catechism of the Catholic Church*, 2280.
[46] For further reading, see John Paul II, *Salvifici Doloris: Apostolic Letter on the Christian Meaning of Human* Suffering, 1984, http://www.vatican.va/content/john-paul-ii/en/apost_letters/1984/documents/hf_jp-ii_apl_11021984_salvifici-doloris.html.
[47] CDF, *Declaration on Euthanasia*, III.
[48] John Paul II, *Evangelium Vitae*, 105.