TRANSCRIPT

An Undeceptions podcast.

John Dickson:

Hey. There's some tough stuff coming up in the next hour, some graphic medical descriptions, and we're talking about people choosing to die and others helping them. If you're struggling right now, please remember or write it down now: in Australia, Lifeline; in the U.S., the National Suicide Prevention Lifeline; and in the UK, Samaritan's Helpline. Stay safe.

Speaker 2:

An Undeceptions podcast.

Speaker 1:

Take me. Did you tell him? Yes.

Speaker 3:

[inaudible 00:00:52].

Speaker 1:

I said to take me. Take me! My [inaudible 00:01:04]. Get out!

Speaker 4:

Duncan! What are they doing to Duncan?

John Dickson:

We're listening to a pivotal scene in the 1992 film the Last of the Mohicans, starring the extraordinary Daniel Day Lewis who's facing a truly awful situation. He had courageously volunteered to be sacrificed in order to save his love interest, but his friend Duncan is taken instead and is being burned at the stake. Lewis's character makes a run for it in shock and now he's standing a few dozen yards away in the forest, undetected, and he watches as his friend is tied up and burned alive. He makes a confronting decision.

He had no chance of defeating all the people involved in the execution. So instead of just standing by watching this man in excruciating pain, he takes out his rifle and he shoots to kill. He puts Duncan out of his misery.

Mercy killings like this are seen as heroic, like in game of Thrones when Jon Snow defies his leader and kills Mance Rayder with an arrow as the flames engulf him. Or perhaps even when Katniss Everdeen

shoots Cato in the head in the 74th Hunger Games to give her fellow tribute a quick death, instead of the agony of being torn to shreds by the wolf-like muts. It's difficult to see this type of mercy killing as evil or even bad in any way and it's this logic that lies behind the popular approval of so called euthanasia, the good death. Here's another real life example. In 2005, a select committee of the House of Lords in the UK heard evidence on a private member's bill on assisted dying for the terminally ill. The committee was hearing the views of a group of people from various religious traditions and one member of the committee describes the following situation, which is often called the policeman's dilemma.

Speaker 5:

It was the case in the United States where a driver was trapped in a burning lorry. There was no possibility of extricating him and he was about to be burned to death and suffer a very painful end. A policeman was on the scene and he asked the policeman, "Will you shoot me?" and the policeman did.

John Dickson:

The committee member then asked the religious panel whether the policeman's actions were justifiable. If you answer no to this question or no to Daniel Day Lewis's mercy killing, you are heartless. At least, that's how many think of it. Of course, if you answer yes, you'll be categorized as someone in favour of legalized euthanasia, but one witness answered the House of Lord's committee in a way that tried to avoid this conclusion.

Speaker 5:

It is a hugely compassionate case and I would do exactly as the policeman did and I hope you would too, but I would not expect the law to be changed to allow that.

John Dickson:

There may be a moral case for individual mercy killings, this witness was suggesting, but that doesn't necessarily justify the legal case. Plenty of things are immoral and legal, think adultery, and plenty of things are moral and still illegal. Think of the person who breaks the speed limit to get a loved one to hospital. It's moral, but it's not actually legal and no one is advocating for lifting the speed limit in a general way. So there's an interesting tension here between the ethical and the legal. Both the Last of the Mohicans scene and the policeman's dilemma are taken from the books of two of our guests today. They are two leading experts in the fields of palliative care and bioethics, and both argue that actually the policeman's dilemma is not the central question. The debate around euthanasia is not actually whether such actions are morally right or wrong and not whether they are compassionate or not, it's about whether mercy killing should be licensed by law.

This episode, we're laying out, we think, the best arguments for and against legalizing euthanasia. My impression is that the mainstream media has already decided there are no powerful, compassionate arguments against euthanasia. It's all apparently just religious mumbo jumbo, but I reckon we might

surprise you. There is a logic and heart in the opposition to euthanasia and religion doesn't necessarily have to feature at all, though you're probably not surprised that I reckon the best arguments against euthanasia can be traced to the historical influence on our society of Christianity, and in particular, to the idea of intrinsic human worth. What view of the human person should our society advocate for, should our society embody in its laws? I'm John Dickson and this is Undeceptions.

Undeceptions is brought to you by Zodervan Academics' Seasons of Sorrow by Tim Challies. Each episode, we explore some aspect of life, faith, history, science culture, or ethics that's either much misunderstood or mostly forgotten. With the help of people who know what they're talking about, we're trying to undeceive ourselves and let the truth out. If this hour of undeceiving isn't enough, join the Undeceptions Plus community for just $5 Aussie a month. That's just two pounds, 83 pence if you are in the UK. You'll get extended interviews with my guests, bonus episodes and tons of other stuff. I tell you, for this episode, our Plus community gets a feast of extras. Head to undeceptions.com/plus.

Can we just sort of, just really briefly, what is euthanasia and how on earth does that word relate to all the new words? Voluntary dying, assisted dying, et cetera?

Charles Camosy:

Well, some rightly say that the terms of the debate can often shape it in really important ways. The term euthanasia, as many of you likely know, just means good death, which of itself kind of presume something about what it is.

John Dickson:

That's Charles Camosy, Associate Professor of Theological and Social Ethics at Fordham University, with a focus on moral theology and bioethics. He's written several books, including Resisting Throwaway Culture and his most recent book, Losing Our Dignity: How Secularized Medicine is Undermining Fundamental Human Equality. Charles has debated some of today's leading philosophers on our topic today, euthanasia, including Australian moral philosopher, Peter Singer.

Charles Camosy:

But if we're going to talk about in different countries now with this debate going on, use different terms, I prefer to use physician assisted killing. Those that disagree with me about this tend to use terms like medical aid and dying or something along those lines.

John Dickson:

Euthanasia is defined by the UK's NHS, the National Health Service, as the act of deliberately ending a person's life to relieve suffering, though our guests reckon there's much more nuance than that, and we'll get to that in the episode.

Can we talk about some philosophical concepts, almost metaphysical, before we drill down to sort of public policy questions? One is the question of moral status and the other is personhood. Can you explain these terms and the role they have in leading us in this debate?

Charles Camosy:

Well, moral status can apply to virtually anything. A famous painting or a tree could have a certain kind of moral status. Personhood is probably best understood as a kind of moral status, so maybe the best kind of moral status, a moral status that is not dependent on anyone or anything, but exists for its own sake. Persons exist for their own sake, not for the sake of anything else. That plays very heavily in a lot of these discussions, at least in my experience as a bioethicist and activist on these questions, because a lot of the most famous cases that have led to the so-called right to die becoming a thing have been judgments made about so-called vegetative human beings, right? Just a totally offensive term to use in my view about a human being. No human being, no matter how profoundly disabled, is a vegetable. That's just an offensive category error.

John Dickson:

Aristotle's lowest form of existence.

Charles Camosy:

Right? I mean, I'm not sure how many people have that in mind when they use it, but it fits very well with that kind of metaphysics. This individual, though still a living, breathing member of the species homo sapiens, like you and I, is now got the moral status of a vegetable. Not of a person, not of someone with rights, not with an alienable dignity and certainly not with equality with the rest of us.

John Dickson:

Aristotle reckoned every living thing had a soul. He didn't mean like a conscious spirit controlling the body. He meant an animating principle. The thing that gave each life form its particular living characteristics. Humans have what he called a rational soul. That is, the unique aspect of our animating principle is that we live according to reason. Then there's the animal soul, which has the power of perception and locomotion, but not reason in Aristotle's view. At the bottom of this hierarchy of souls are the souls of plants. Plants have a vegetative soul, which can't reason or perceive, and which can't move in the sense of locomotion, but it still has a soul in the sense that it has powers of nutrition, growth, and even reproduction.

In the late 1800's, back in the day when people were still routinely reading Aristotle, they started to describe comatose patients as vegetative in a slight nod to Aristotle's schema. A rational soul in this case had fallen to the vegetative state. It's still a living being with an animating principle, but it's not a living being at the height of soulish powers. More on that in the show notes, which is where producer Kayley thinks this whole Aristotelian chime belongs. Boo.

Charles Camosy:

In my most recent book, Losing Our Dignity, which came out this past summer, really drives this home, saying once you make a distinction along these lines, once you say there are persons and there are human beings and maybe those categories aren't coextensive, maybe there are human beings that are not persons, you really open yourself up again to the critique that so many anti-ableist groups really point out, which is you're making judgments about what kind of lives are worth living in and what aren't.

John Dickson:

Because it's capacities oriented, isn't it?

Charles Camosy:

Exactly.

John Dickson:

We all have different capacities.

Charles Camosy:

That's right.

John Dickson:

If value is dependent on capacities, we all have different values. So we might as well put ourselves from top to bottom.

Charles Camosy:

Right. Some of the most viable candidates now, especially as the West has secularized, that we moved away from this idea that we have equality based on being made in the image and likeness of God, we move into things like autonomy, rationality, self-awareness, capacity to have moral reasoning, will. Productivity, especially in the consumer West, productivity becomes important. Are they a productive member of society? Obviously what you just said is just completely correct. I mean, the idea that equality could be based on any of those things is just nonsense because we obviously have radically different capacities among human beings with regard to those traits and some human beings appear not to have those traits at all, or many of those traits at all. So when we think about moral status and personhood, we become increasingly comfortable in ways that I find disturbing anyway.

We're saying there are things called human non-persons, fellow members of the species homo sapiens, who, because they don't have rationality, self-awareness autonomy, et cetera, don't count the same as the rest of us and therefore it's much easier to explain why we would stop feeding and hydrating them or why we would give them an injection of something or why we essentially give them, as happens, at least in my country, when someone has later stage dementia, we give them antipsychotic drugs to keep them

docile, essentially give them a chemical straight jacket until they die. I mean, these are practices wrought of that distinction between human being in person, in my view.

John Dickson:

This would be the view of that great Australian export Peter Singer.

Charles Camosy:

Yeah, and to be honest with you-

John Dickson:

Peter Singer is an Australian moral philosopher and professor of bioethics at Princeton University. He's been described as the most dangerous man in the world for his challenge to the sanctity of human life. Singer argues that not all humans are persons. To qualify as a person and therefore receive moral consideration, a being must be self-aware and capable of perceiving themselves as individuals through time. In this view, newborn infants are not persons in the full sense, and neither are some of those people with lifelong cognitive disabilities. Someone with Alzheimer's disease or advanced dementia is losing personhood and Singer argues that killing a non-person doesn't carry the same weight as killing a person.

Frankly, his view is a return to the capacity's view of human value that was everywhere in the Greek and Roman world before the influence of Judaism and Christianity. It is, frankly, a logical view if you don't happen to think there's any transcendent grounds for believing that humans are inherently precious, regardless of abilities.

Charles Camosy:

To be honest with you, I wrote a book on Peter Singer called Peter Singer and Christian Ethics Beyond Polarization. I became a vegetarian because of him. I respect him deeply on poverty. I even, even though I fundamentally disagree with him about these questions, I have a grudging respect for someone like him who's willing to say, "Hey, my mom who is later stage dementia, it turns out she doesn't count as a person in my view." Right? I think he's just profoundly wrong about that. But this is ... when it comes to abortion, when it comes to vegetative state, when it comes to many other issues, the West has kind of capitulate on this and said, "Yeah, we're going to make distinctions between human beings and persons, but we're going to stop it here. We're going to arbitrarily say it's not going to go this way. It's not going to go to infants," which of course, newborn infants, aren't more rational or self-aware than the family dog, when they're first born and Peter Singer says we should be pro-choice for infanticide for that reason.

He's right. He's not right about the foundational moral judgment, but he's right about saying, if you make that moral judgment, this is what follows and he is right about dementia too. So Peter Singer has got problems with his views, but at least he's got the courage of his convictions to follow the line of argument, wherever it leads.

John Dickson:

Yeah. So are you saying life should be preserved at all costs, that there's an absolute duty to sustain life? Is that the tradition you're coming from?

Charles Camosy:

No. No, not at all. So making it clear that so-called vegetables are full human beings like you or you and me, that prenatal human beings are human beings like you and me, that our grandparents or parents, when they reach the later stage of dementia and lose their rationality and self-awareness, at least as you and I have it, remain like you and me, it doesn't follow at all that we just do everything we possibly can to keep them alive. It does follow we don't aim at their deaths, I would say. It does follow that we don't say, "It's time for you to die now." But especially speaking as a Christian theologian and bioethicist, we have this long tradition, which has basically been adopted, frankly, by secular traditions of distinguishing between means of treatment that's ordinary or required and means of treatment that's extraordinary and can be forgone.

John Dickson:

This is an important point. The position that Charles is putting forward here, the Catholic position, I guess you could describe it, is not that life must be preserved at all costs. The Catholic catechism, which is the central explanation of Catholic doctrine, says this; discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate. It is the refusal of overzealous treatment. Here, one does not will to cause death. One's inability to impede it is merely accepted. That's the Catholic position. It is immoral to end an innocent person's life, but it isn't immoral to cease over zealous treatments. This is a fairly widely accepted distinction among Protestant thinkers as well.

Charles Camosy:

This goes all the way back actually to the battlefield physicians of the Middle Ages who said, "I got this guy who's going to need his leg cut off on the battlefield. Can he tell me he doesn't want that, even if I know that he's going to die as a result?" The moral theology of the Middle Ages said yes and it's not participating in his suicide, the soldier's decision isn't one aiming to his own death, but makes a distinction between extraordinary and ordinary means a treatment, treatments that's required, treatments that's not required. In fact, if you just look at, especially the Christian tradition, you look up at Christ on the cross, you look at the martyrs, obviously preserving your own life at all costs is not part of the story, right? In fact, there are many other goods that are more important than preserving your own life and preserving the life of others that should be aimed at.

But sometimes that distinction gets lost, right? Sometimes the idea that we want to say, no, every person matters just as much as every ... every human being matters just as much as every other human being,

we then conflate that with well, we need to spend $14 million to squeeze every minute out of somebody's life. One doesn't follow from the other.

John Dickson:

Do you think there's a difference between killing and allowing to die? Like a real difference? Because that would then just come down to intention.

Charles Camosy:

Yeah, but I think intentions really matter a lot. I guess I make a bad consequentialist. The definition of-

John Dickson:

A consequentialist in ethics is someone who believes that whether something is good or bad really just depends on the outcome. It's not about virtues or even intentions. It's just about what brings about benefit or harm. Charles is not a consequentialist. Nor am I.

Charles Camosy:

So the definition of euthanasia and assisted suicide that I use is an act that of itself or by intention causes death. So it is an act or an omission. So, yes, I mean, if I intend someone to die by omission, that doesn't seem hardly at all different from intending someone to die by an action. The example I sometimes use with my students is dramatic, but I think it makes the point. So imagine a scenario where a husband wanted to kill his wife for the life insurance money, and she's taking a bath and he's ready to drop the toaster in the bathtub and he sees that she's drowning at that time and just lets her die by intention, right? He could easily save her, but he decides not to. To me and to most of the people I engage with that thought experiment, they say, "Well, the guy is a horrible person, obviously, no matter what, but he's not a more horrible person because he drops the toaster in the water any more than if he just simply allowed her to die because he wanted the life insurance money in both cases."

So for me, and for many coming out of sort of my school of thought on this, the real thing to decide is whether somebody is aiming at death and to get back to the soldier on the battlefield, the soldier is obviously not aiming at his own death by saying, "I don't want my leg cut off of the Middle Ages without any kind of pain medication." Right? He's aiming at something else. He doesn't want his leg cut off without pain medication. By the way, if he would survive, he would be thrilled because he, of course, was not aiming at his own death. He was simply aiming at not having his leg cut off without pain medication. So that's, again, back to this distinction between ordinary and extraordinary means of treatment.

John Dickson:

The distinction between ordinary and extraordinary means of treatment goes back at least to medieval thinkers, like Thomas Aquinas. Three cheers for the Middle Ages, right? And for Aquinas. Anyway, Charles writes in his book, titled Peter Singer and Christian Ethics, that this tradition has influenced and been

invoked in the wider secular debates on this issue. Here's another textbook example Charles raises in his own book.

Speaker 5:

Janice was diagnosed with ovarian cancer after months of non-specific symptoms. When the cancer was finally discovered, it had spread to other parts of her body. The doctors were not optimistic-

PART 1 OF 4 ENDS [00:23:04]

Speaker 5:

It had spread to other parts of her body. The doctors were not optimistic about her prospects. But told her that with investigational doses of chemotherapy, they may be able to buy her some time, perhaps as much as a year. If sustaining life were the sole benefit Janice was considering, she would've jumped at the chance. However, as it was, she debated whether to undergo chemotherapy at all. In talking with the doctors about treatment, she wanted to know how much pain she would experience, whether her insurance would cover the costs, how her relationships with her only child and other loved ones would be affected, how much time she would have to spend in the hospital and whether she would be physically capable of working and pursuing her life's passion of painting.

John Dickson:

In this scenario, Janice could refuse the life sustaining chemotherapy, as long as she was making a choice about how to live, rather than intending or willing her own death. Euthanasia is wrong on this view, where an action or omission actually intends to bring about death. Euthanasia, allowing someone to die, is wrong according to Camosy, only when we intend to cause that death. If Janice refuses chemotherapy because she wants to die, then this omission would still be euthanasia, she is aiming at death. But if Janice simply determined that the chemotherapy was too great a burden to bear, that it would curb the kind of living she wanted to experience right to the end, then her refusal to take the medicine isn't aiming at death. It's aiming at relieving the burden of treatment. She foresees death, of course, but she doesn't intend it. Now this may seem like a subtle difference. It's not. Our intentions really matter. And when the intention to end life creeps into public policy, into our laws, we've become a very different kind of society.

I want to get you to tell us about The Last of the Mohicans, and the way you use this as a story about medical ethics.

Charles Camosy:

Oh, John, this is both good and bad. You jumped me with a really hard one, but it's one that I really love.

John Dickson:

It's an awesome film.

Charles Camosy:

And I often use that case as an example that challenges my own point of view on this. Am I saying, and are those of us who don't want assisted suicide, euthanasia, saying that Daniel Day-Lewis's character did something wrong by directly aiming at the death? Now he was doing it as a means to saving the British soldier pain, but the means by which he accomplished the end of his act was in fact the death of the soldier. So he can't complain, he can't use the view of the medieval soldier to say, ''Well, I wasn't aiming at death here.'' Or the medieval physician, ''We weren't aiming at death here.'' He was aiming at death, as a means to some other end. And here is where I just have to bite the bullet and say maybe yeah, maybe yeah. But every position actually one takes on this is, and this is something I think every student of these issues really has to absorb, is going to lead them to counterintuitive positions. There is no position, when it's followed through consistently, that doesn't lead to counterintuitive positions.

John Dickson:

Yeah. So there's something very interesting here. Are you saying you can almost, if you squint, see why Daniel Day-Lewis' character did something good in that individual case?

Charles Camosy:

Oh yeah. If I was just coming brand new to this discussion and I hadn't thought through these positions carefully, I hadn't thought about them, if you asked the sixth grade me, the 12 year old me, about this, I would say, ''Well, of course. It's not only right, it's totally badass. It's courageous. It's, it's heroic what he did.'' But that's why ethics, frankly, is more difficult than just looking at the intuitions of 12-year-olds when they watch a movie. It's important to dive in to the complexity of the issues, and to see them in all their complexity and in all their nuance, and how they're connected to other issues. And if you go in this direction where that leads, and if you go in this other direction, figuring out where that leads. And again, there is no position to take on this that doesn't, when followed consistently, lead you to a counterintuitive conclusion.

John Dickson:

Yeah. So do you have an argument to help your students, does the grown up Charles have an argument, to lead students to think, ''Well, actually, Daniel Day-Lewis did wrong.''

Charles Camosy:

Yeah. So it comes down to this idea about the dignity of the human person and about aiming at their death. If you have a principle that says, you know what, we should not aim at the deaths of innocent people, 85% of the time. Maybe this is a rule utilitarian approach here. It maximizes good consequences to have this rule. There's nothing about the rule that is inherently connected to human dignity. Who even

believes in human dignity anymore? It's really just a best practices type rule that we've had for a long time, that seems to work best. And then maybe you should violate the rule every once in a while, like Daniel Day-Lewis did, when it makes sense. That's a pretty good rule, consequentialist analysis. It's a terrible analysis when it comes to human dignity.

If we say every life, literally every life, has the kind of value that you ought never to act against its good. You may not preserve it in every circumstance. You may not do everything you can to keep it alive, but you ought not to directly act against its good. That is a very different kind of analysis of what's going on. Now interestingly, rule utilitarians and more human rights and justice-centered people who want these rules to defend human dignity, can agree on maybe the rule, even the policy perhaps. Which is important for thinking about pluralism and public dialogue and debate on these questions. But it's a very different kind of moral analysis. It's an analysis which invokes a very thick vision of the good, a very thick vision of human dignity, a very thick vision of human action.

But again, these kind of, to use a fancy phrase, exceptionialist moral norms are not limited to this. We tend to think of torture for instance as being a similar kind of example. So if we say torture is always wrong, full stop, or maybe it's 85% of the time wrong, I'm the one who's going to say you shouldn't torture even if it's the classic ticking time bomb scenario. I'll also say the same thing about sexual violence, or a host of other issues, that for which we should have, in my view, very clear exceptionialist moral norms. Even if you can tell the story again, where you put yourself in a awkward situation where a lot of people are going to be disappointed with you, or have questions, it's important from the standpoint of respecting human dignity, to have those exceptionalist moral norms.

John Dickson:

For Charles, Daniel Day-Lewis's character may be heroic, even compassionate, but he was also wrong to kill Duncan. And it would be wronger still, to legislate that such mercy killing was permissible. After the break, we're going to hear more from Charles, as well as from two specialists in palliative care, from opposite sides of the world. We're going to confront the best arguments for and against euthanasia, including the dreaded slippery slope. This episode of Undeceptions is sponsored by Zondervan Academic's new book, Seasons of Sorrow by Tim Challies. In 2020 Tim's son Nick passed away suddenly and unexpectedly. As a prolific writer and blogger, Tim says that he had to write to help him process the grief. And those meditations formed the basis of a book that Tim now hopes will encourage others who are going through deep sorrow.

Tim:

The Seasons of Sorrow is about a time my family went through, shortly after my son passed away. He was a seminary student, 20 years old, and very suddenly unexpectedly passed away of an undiagnosed heart defect. And in the aftermath of that loss, I didn't really know what to do but to write. Writing is how I think, it's how I process events. And so in the year that followed I just found myself writing lots and lots. Trying to process our loss. And in the end realized maybe this could be helpful to other people. Yeah it

obviously comes right from the heart because the loss was so deep, so grievous, that I was trying to apply truths I knew to a real-life situation.

When we go through one of those seasons of sorrow and loss, I think we all cast about for something that will stabilize us. We have to find something that's true, that's going to be our starting point for working out what has happened, for processing it in our minds. And whether you believe in God as we do or whether you don't, you're going to have to find something that will stabilize you. My heart is broken. My mind is reeling. What does it mean now to say, ''This is going to be my starting point, is the existence of God, the character of God, and so on.''.

I had an intellectual Bible-based understanding of suffering, why we suffer, I had studied that. I had read the books. I had that foundation in place, but I didn't experientially know what it is to suffer in that way and a really grievous sorrow or loss like this one. And so it was very much then looking back to what I believed, in saying, ''How is that going to help me now?'' Because in this moment I'm either going to throw it all away and say, ''That can't help me, so therefore it's all junk'' Or I'm going to say, ''No, this is really true. I'm going to believe this is true.'' And by faith, I'm going to then apply it to my life and say, ''Well, how can I live like this is true? What difference does the death and resurrection of Jesus make right now in this time of deep sorrow?''

John Dickson:

It's so difficult to talk about suffering and God in the abstract, it can almost feel callous and unfeeling. Hearing from Tim about how he had to work out his faith through this terrible scenario is confronting. But for those in the midst of suffering of their own, whether fresh or fellow, Tim offers companionship, honesty and ultimately encouragement. we're going to talk to Tim a lot more in a future episode of Undeceptions. For now though, you can order Seasons of Sorrow on Amazon, or go to zondervan.com for more information.

In Tanzania over a third of girls are married before the age of 18. It's often because there aren't many other options. Almost 70% of children, aged 14 to 17, in the country aren't enrolled in secondary education. And in a culture that doesn't highly value women, school is a really low priority for them. It's considered much more useful for a girl to be managing the home than traveling the often long distances to go to school. So they're pushed to be a homemaker as soon as possible. Anglican Aid is working to prevent this, with local Christians in Tarime in the Mara Region of Tanzania. What they're doing is offering local young women an alternative. They want to build the Tarime girls secondary school, which when complete will offer places to about 800 girls. Giving them the opportunity to complete their secondary education, keeping them at school and avoiding young marriages. You can help Anglican Aid in this important work, valuing women and championing education. It's an organization I really trust. Go to anglicanaid.org.au to give today.

How has the conversation about death changed over recent decades?

Ilora Finlay:

Well I think, if we go back 30 years or so, people were not talking even about serious illness and there was a death denial in society. And now people talk openly. So when you see your doctor, you expect to be told the truth about your diagnosis, not some little euphemism. And we now include children in funerals and all of the hiding away has gone. And I think we talk much more openly, generally, about death.

John Dickson:

That's Baroness Ilora Finlay of Llandaff, a Welsh doctor and professor of palliative care medicine at Cardiff university. She's also a member of the House of Lords, the upper house of the parliament in the UK. Baroness Finlay has previously been the president of the Royal Society of Medicine and is co-founder of the UK think tank Living and Dying well. We'll hear more from Baroness Finlay a little later. She's right in saying that our perception of death is ever evolving, but of course, death, and even assisted dying, are not new.

Plato and Aristotle were mostly opposed to self killing, except in circumstances where there was a massive preponderance of hardship. They essentially agreed with euthanasia in some cases. The later Stoics, like Cicero and Seneca, were even more relaxed than that. They thought that life should be preserved only when someone was in possession of the key aims of life, including health and vitality. But when someone loses those things, or has a serious prospect of losing them, ''It is appropriate for them to depart this life.'', said Cicero. Then there's the ancient physician Hippocrates and his famous Hippocratic oath, which seems to suggest that no physician should ever assist in the harm or death of another person. If you've never read the Hippocratic oath, it's actually pretty cool. And here's the Undeceptions' house voice actor, Janik Laurie, reading a translation of this influential ancient Greek text.

Speaker 6:

I swear, by Apollo the physician, and Asklepios, and health and all heal, and all the gods and goddesses, that according to my ability and judgment, I will keep this oath and this stipulation, to reckon him who taught me this art, equally dear to me as my parents. I will impart a knowledge of the art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath, according to the law of medicine, but to none others. I will follow that system of regimen, which according to my ability and judgment, I consider for the benefit of my patients and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel. And in like manner, I will not give to a woman, a pessary to produce abortion. With purity and with holiness, I will pass my life and practice my art, while I continue to keep this oath unviolated. May it be granted to me to enjoy life and the practice of the art, respected by all men in all times. But should I trespass and violate this oath, may the reverse be my lot

John Dickson:

Hippocrates, though a Pagan, sounds remarkably like the ancient Christians, who uniformly condemned all forms of taking innocent life. The role of medicine was only ever to mend, to do good, not to harm. And the Christians maintained this viewpoint, not as some cool theoretical doctrine. We mustn't forget, one of the best kept secrets of history is that churches were the principal source of healthcare in society, from the 300s AD, when they first invented the public hospital, more on that later, right through to the early modern period, when churches were responsible for literally thousands of hospitals, hospices, lepresoria and aged-care services. These church-run facilities embodied the Hippocratic tradition of acting only for the benefit of my patients at abstaining from whatever is deleterious. And this remains one key argument against euthanasia. Euthanasia introduces a new and foreign idea into medicine. Medicine, not as mending, but as ending.

You often hear people say, ''But you are doing good to patients in euthanasia by relieving their suffering.'' Actually, that's a bit of a word game. Logically, you can't be doing good to someone by removing their very existence. In that act, you are removing the very object of your good. This was the Hippocratic and Christian view for centuries. It was only in the modern period, in the Renaissance and the Enlightenment, that people reached back to classical writers, like Plato and Cicero, to argue that voluntary assisted suicide, for those who are suffering, is morally permissible. And the argument has been gaining ground ever since.

Our new medical context has also radically changed things, because the extraordinary advances in medicine mean that we have expanded lifespans and we've changed the disease landscape. We're no longer likely to die from acute diseases, the ones that kill us really quickly. We're more likely to die of chronic disease, long-lasting conditions like heart disease or cancer. And it's the prospect of long drawn out death that in part motivates our contemplations about euthanasia. But that might not be the real reason for growing support for euthanasia.

You might remember the bioethicist, Margaret Somerville, who appeared in our Pro Life episode. She writes in her book, Death Talk, that the real reason for increased support for euthanasia, may be our culture's intense commitment to individualism and autonomy. We think less today about the kind of community we want to be, less about what should be the public view of death, and much, much more about what I want and whether you have any right to get in the way of what I want. There's something to that analysis.

So at the high level, what are the most common arguments for euthanasia or voluntary assisted dying?

Charles Camosy:

Well, in my experience, they tend to focus on autonomy, so personal individual freedom. And autonomy, I'm in the United States, and we have a long tradition of thinking about personal and individual autonomy, especially in relationship to the state. This especially comes up in our abortion jurisprudence, but it's definitely something that's very much part of the discussion about euthanasia and assisted suicide as well. And so the argument is pretty simple actually, that I hear most often, it goes something like this, ''I have the freedom to decide about the most important things in my life, the things that I hold

most dear. It's hard to imagine something more important in one's life than deciding how one dies. And so we don't need the interference of government, we don't need the interference of the state to intrude on my own personal autonomy and freedom to make these decisions how I want to make them.'' There are other arguments, but that's the one I hear most often,

Ilora Finlay:

The worry that I have with the term autonomy is that there is a view that if you want something, you can get it, but without necessarily looking at what is the effect on other people. And actually the original principle of autonomy is that the autonomy of one person cannot override the autonomy of another.

John Dickson:

One version of the autonomy argument expresses things in terms of moral agency. We are moral beings. It's one of the most important things about us, that we have agency to make our own decisions regarding ethics and so on. That's fine, so far as it goes, but of course we curb people's moral agency, moral decision making, all the time when there is potential harm to others or to oneself. And there's a more logical problem too. Ending someone's life isn't an expression of their moral agency. It's the negation of their agency, of every kind of agency. When loved ones fight for the patient's continued existence, they are fighting precisely for their continued moral agency. They are refusing to participate in the destruction of agency itself.

I want to throw a couple of arguments at you that I hear. One is the economic argument. Think of all the money that could be saved, in the whole national health system, if we did allow people to end their lives. And that money could be distributed to better research, cancer research and the like.

Ilora Finlay:

Right, the reality of the way that health budgets work is-

PART 2 OF 4 ENDS [00:46:04]

Ilora Finlay:

The reality of the way that health budgets work is that firstly, the money doesn't get reallocated. That just doesn't happen. And secondly, if you want to save money in the healthcare system, make it more efficient, avoid wastage, look at the wastage, phenomenal wastage in healthcare. Look at the complete wastage. We've got to tackle the green agenda. And yet we're still using plastics like crazy in healthcare. We're throwing things away. The electricity bills are huge. We've got drug wastage because of overprescribing. That is a really fallacious argument and it's over simplistic. And it's actually saying that people who are seriously ill are worthless, so we should throw them away.

And you could extrapolate that to say, "Well, what's the point of providing any medical care at all to somebody who's seriously ill?" Because chronic diseases in Western society are the big problem. Well, if

we stop treating them, look at the money we'll save. Why are we treating malignancy, cancers with a poor prognosis? We're doing it because we are trying to gain months or a couple of years. That argument about budgets would say, "Well, that's a waste of money. Just give them lethal drugs now."

John Dickson:

I guess those who are supporters of euthanasia would say, "But we're only talking about those who really, really want to end their own lives."

Ilora Finlay:

Well, I think the problem is if you look at what happens in all of the places where the law has changed, the numbers rise exponentially. It becomes a default way to die, but it also becomes a default way to die early. And of course you don't know what you've missed out on.

John Dickson:

Do you think this right to die or autonomy vision that seems to be dominant in our society necessarily leads to a perception of a duty to die? That the right to die does lead to the perception of a duty to die, because some will say, "That's just alarmist, that idea."

Charles Camosy:

Here, I follow the disability rights groups again on this. It's a real, real concern. And we've seen it happen already. The State of California in the United States recently legalized physician-assisted suicide. There, as has happened elsewhere, somebody with later stage cancer wanted an experimental treatment funded by the state healthcare system. They said, no, but they said, "Hey, we'd be happy to give you assisted suicide instead." So there's the structural problems. The unintended consequences that come from these laws that often get overlooked, at least in my experience-

John Dickson:

Just a bit more on that California case from 2015. Stephanie Packer was 29 when she was diagnosed with scleroderma, an autoimmune disease that causes hardening of the skin and sometimes hardening of the organs. The doctor told Packer that it had settled in her lungs and she was given just three years to live. Her insurance company refused to pay for the chemotherapy that would help extend her life. But when Stephanie, out of curiosity, asked if they would pay for medication so she could take her own life under California's new End of Life Option Act, she was told yes, they would pay for that with a co-payment of just $1.20.

Now, it's important to say that the insurance company didn't come out and offer Stephanie euthanasia as an alternative to chemotherapy. They were just responding to her explicit question, "You won't pay for my treatment, but will you pay for my euthanasia?" It turns out the insurance company did eventually pay for her chemotherapy, good on them. But in those few moments before, Stephanie was in the

bizarre situation of being told that life-extending drugs would cost her thousands and thousands of dollars, whereas life-ending drugs would cost her just over a dollar.

Charles Camosy:

Now, that is probably not the, I'm quite confident that's not the scenario that people of good will who disagree with me about these issues who voted for physician-assistant suicide being legalized in California, that's probably not what they wanted, but it created a structure that had unintended consequences for this person and for many different kinds of people now. And we can extrapolate from that, can't we? To how other pools of money and people thinking of themselves as burdens might also think about their duties.

John Dickson:

The strongest arguments against euthanasia, Camosy reckons, come from disability advocacy groups.

Charles Camosy:

Probably the most powerful resistors of physician-assisted suicide and euthanasia are not religious organizations. In fact, religious organizations have made a strategic play actually to step back from leading the resistance and let disability rights groups really take the lead on this. And so yes, one might approach this from the standpoint of a religious belief and the sanctity of all human life and nonviolence and care and compassion for the most vulnerable. Suffering with them, true compassion. Compassion means suffering with, right? Suffering with somebody rather than giving into a throwaway culture as Pope Francis talks about.

But one could easily make a very different argument, and this is the argument that disability rights groups almost universally make, which is, once you start making judgements about what kind of lives are worth living and what kind of lives, well, we can kind of understand why you'd want to kill yourself if you had that kind of life, that is extremely dangerous territory for the disabled. And in fact, we've seen in places where euthanasia has been around a long time, not just freedom and autonomy for those that want to do this, but a kind of social structural pressure on those who fit into the category that we've decided, well, we can understand why you'd want to kill yourself, to in fact, kill themselves, or even in the structures of limited healthcare resources.

In Oregon, they've had assisted suicide since the '90s, and we have good data on why people request assisted suicide in Oregon. Number one reason is not pain. In fact, pain, physical pain doesn't even make the top five reasons why people in Oregon request assisted suicide. The number one reason is fear of loss of autonomy. Back to the autonomy thing. I forget what number two is, but number three is not wanting to be a burden on one's loved ones.

And often people have multiple reasons for wanting this. Now, if you think about loss of autonomy and you think that's very, very much about, you can understand why disability rights groups wouldn't want that to be the number one reason people request this, right? But also, if you hone in not wanting to be a

burden on others, if that's number three, which last time I checked, it was number three, that's the classic example of the right to die becoming the duty to die, because one is so full of guilt and the sense of not wanting to burden others that one thinks, "Well, maybe it's time to request assisted suicide, precisely because I don't want to be a burden on others."

John Dickson:

Camosy is quoting the annual statistics released by the Oregon State Health Department in the US. Being a burden on others is the number four reason at 54.2%. Over half of those wanting to end their lives through euthanasia want to do so in significant part because they don't want to be a burden. The top four reasons by the way, are one, losing autonomy, 93.3%. Two, less able to engage in activities making life enjoyable, 92%. Three, loss of dignity, 68.1%. And four, burden on the family, on friends and carers, 54.2%. And that number, the don't want to be a burden number is rising. People are increasingly saying that a key reason they are pursuing euthanasia is the fear of being a burden. Imagine if that continues to rise, imagine an increasing sense on the part of the very ill that it would be better for others if they were dead.

Now, I'm not even introducing the notion sometimes raised that we also have to think of family members who pressure loved ones toward euthanasia, because it would be easier on them or because they want the inheritance. My point is that patients themselves, regardless of external family pressure are increasingly feeling they ought to make things easier for others by exiting life. It's an example of how broader societal attitudes can have real life, real death consequences.

Maybe the best test case is the Netherlands. So I want to talk about the Netherlands with you, if that's okay. Am I right they settled this question ages ago?

Charles Camosy:

Yes. Even longer than Oregon, they've had it over there.

John Dickson:

And what changes or evolution have they seen over the, whatever it is, 30, 40 years they've allowed euthanasia?

Charles Camosy:

Like many places, they've tried to keep it under a certain, very strict set of requirements, but especially in the consumerist autonomy-centered West, it's really hard to do that. Why 6 months? Why not 12 months, that a doctor says, "You're going to die within 12 months." Isn't that arbitrary? If it's about autonomy, it's about me deciding about my life and my death and my body, my choice, then it seems arbitrary to say that if I'm going to die within four months, I get it. But if I'm going to die within eight months, I don't get it. Especially if I might be seriously suffering during that time.

I'll get back to Netherlands in a minute, but in Oregon there were attempts to make it the threshold go from 6 months to 12 months, but they were rejected actually by the campaigners for the right to die movement, precisely because they knew people like me would use that as a talking point that said, well, some people might be sympathetic to have it in this case, but there's really no way, especially in an autonomy consumerist-centered ableist culture that it's going to be limited to that, eventually it's going to be pushed to something else. And the Netherlands really describes that situation.

So they did try to keep it fairly narrow in the number of cases that it would apply, talked about extreme and unbearable suffering. But again, if it's an autonomy-centered culture, who's to decide what extreme and unbearable suffering is? Who's to decide whether this is physical suffering or whether this could be mental suffering? I think fairly recently, there was a woman who was suffering as a result of sexual abuse who requested physician-assisted suicide and got it. Is that the kind of compassion we're looking for in a Western culture? Or is it just again, autonomy? My choice, my right, my life, my death. And physicians are like Burger King now, essentially just making the Whopper to order. There's no sense of objective right or wrong. No objective sense of what health is or what it means to practice healthcare, it's just giving people what they want.

John Dickson:

Charles says that the fastest group in the Netherlands requesting physician-assisted suicide are people over 80 in nursing homes who are simply, "Tired of life." "And who can blame them?" He argues, "Given what they are told about what their lives are worth or what their lives are not worth." It's not law yet, but the Netherlands and Belgium are currently debating whether being, "Tired of life," or having a sense that your life is already complete, should be legal grounds to request physician-assisted suicide. Again, the question isn't just, does grandma have a right to end her own suffering? The question is, are we happy living in a community where being a burden and tired of life are considered reasonable grounds for someone ending their own life and others helping them to do it?

Charles Camosy:

And here's yet another example of the slippage going on in the Netherlands. There was, and this connects to dementia in a really important way. And I mentioned this in losing our dignity. There was a woman with early stage dementia who requested assisted suicide, but then later as the dementia progressed, they checked in with her again. And they said, "Are you sure you don't want to do this?" And she said, "No, not yet." And they asked her again and she said, "No, not yet." And then they asked her a third time and they said, "No, not yet." The medical team and her family were starting to get frustrated because they had decided this is what was in her best interest, she had requested earlier. And so their solution to this problem was to essentially give her a sedative in her coffee and kill her without her consent. The physician who was involved in this was recently found, relatively recently. I think it was last year, was found not guilty of anything by a Dutch court.

So when something like that can happen, you're seeing the kind of slippage where we go from again, my life, my autonomy, my body, my choice to a culture of deciding, well, who would want to live a life with later stage dementia? Well, it was this person who said that she didn't want to die, but she was killed anyway.

John Dickson:

Some might hear that and say, "Oh, but that's a complete outlier." Isn't it 99.9% of the cases of euthanasia have the consent, even the passionate consent of the person suffering?

Charles Camosy:

It depends what you mean by euthanasia again. If we make a distinction between active euthanasia, which is a planned thing where there's a direct killing of somebody or the direct assistance of killing, that is probably right. But again, if we go back to a distinction made earlier or a non distinction maybe made earlier, we are aiming at death by omission all the time. And this is one of my big fears about dementia, is that we're already aiming at death already by saying again, "We'll give you these antipsychotic drugs, we'll essentially put you in a chemical straight jacket. We don't have enough resources to really care for you properly. You'll be separated from your family. You'll lead this meaningless existence. Maybe we'll even..." This is starting to happen now. "Maybe we'll even create robots to take care of you." The idea that an algorithm can care for somebody is totally ridiculous, but we use that language.

People are eventually going to start saying, and already started saying, "Well, that is a horrible way to live. Maybe I would just want request assisted suicide in that scenario." And I can understand, again, back to the squinting point you made earlier. If I squint, I can understand why someone would say that. If the alternative is that, that's not only a terrible alternative, it is, I need to think about it more of... It's in some ways, so close to aiming at death. It's essentially giving somebody a chemical straight jacket and waiting for them to die. That it's at least akin to the kind of thing that would happen in a direct killing or a direct assisted killing

John Dickson:

People mock the slippery slope argument. If you start talking about something that happened in some exotic country, they say, "Ah, that's just a slippery slope argument." And the argument's over. But what do you think we can learn from countries that are, let's say progressive on the euthanasia front?

Ilora Finlay:

Well, what we see is quite apart from the numbers going up pretty exponentially. I mean, if you even look at Oregon, which only has assisted suicide, the number of lethal drugs prescribed increases by over 13% every year on average, and the number of people who die by ingesting these drugs goes up on average year on year. The same in the Netherlands, the same in Belgium, where even half of them are

now not reported. And the gradient, the slope in Canada is really alarming. The gradient is really steep. The numbers are going up hugely.

But the other thing is that you see that the boundaries for the law change, we see this expansion of the law in all of the countries, one way or another. Oregon has dropped its cooling off period, that's gone down. In Belgium, there is a probably 40 to 50% not reported. There's no sanction against doctors there. In the Netherlands, the number have gone up, the number of young people, people with learning difficulties, where you really worry about their capacity to make the decision. And in Canada, we've seen people go to court to try to get the social support that they need to live and live well, which they can't get, but they're offered euthanasia. So I don't call that a slippery slope. I call that a society that abandons any sense of duty to care for its own citizens who are in straitened circumstances for whatever reason.

John Dickson:

By the way, producer Kaley has put links in the show notes to all of these studies and cases so you can read about them for yourself. The slippery slope argument is scoffed at, but Camosy warns against dismissing it out of hand.

I'm sure you've had people just say to you, "Oh, that's just a slippery slope." We never stop to think whether slippery slopes are real and bad. It's almost like you just say those words and I've defeated you. What's your defence of slippery slope arguments?

Charles Camosy:

It's like every other kind of argument. If it has no evidence, then you should dismiss it. But we've already talked about several examples in the West about the slippery slope. And we've even talked about an example where activists for the so-called right to die have explicitly worked against the slippery slope happening, going from 6 weeks to 12 weeks in Oregon, for instance, because they want to avoid rightly being charged with the slippery slope critique. The people involved here are not dumb. They're smart. They know what arguments need evidence in order for them to work, but even despite that, there's enough evidence to point you to go around where it's not at all an evidence free argument. And again, if you just do the math about autonomy and freedom being the basic driving forces here, why would anybody say to anyone, if that's what is really driving it, that 6 months or 12 months is the business of the government. That's got to be the right of an individual to make up their mind for themselves about that.

Andrew Denton:

My dad, Kit, used to joke that he wanted to go by walking into the shallow end of an Olympic-size pool filled with single malt whiskey and just keep walking. Sadly, that never happened. Watching him die remains the most profoundly shocking experience of my life. With-

John Dickson:

My we're listening to a clip from the first episode of the podcast, Better Off Dead created by the brilliant Australian TV and radio personality, Andrew Denton. Denton has become one of the most high profile advocates of euthanasia in this country.

Andrew Denton:

... with my sisters, Jo and Pip, I stood helplessly by as death picked up this strong man and shook him out until he was nothing. Dad did not go gentle. Although clearly dying of heart failure and obviously in great pain, he was assisted to die in the only way that Australia's law then and now would allow. He was given increasing doses of morphine to settle the pain, but morphine never did settle the pain, not his and not ours. The images of those final three days will never be erased.

I couldn't help but wonder, to whose benefit was dad kept alive for three more days of pain? Wouldn't it have been better instead to help him die quickly and peacefully?

John Dickson:

Euthanasia advocates often see themselves as the compassionate ones and someone like you is the called academic. Do you feel the force of that?

Charles Camosy:

I feel the force of how that appears on Twitter or something. It's a lazy, deeply misguided position. The Calvary Hospice Center, just north of where I teach in the Bronx, New York is a Catholic-run hospice centre that never does any sort of thing remotely resembling euthanasia. And all of their dying patients feel, with rare exceptions. You should never say all, but the overwhelming majority of their patients feel totally, totally welcomed and loved and cared for, suffered with again, compassion. And they have no option to be killed via euthanasia or assisted suicide. Probably true in Australia, as it is in many countries where the Catholic church and other Christian churches have a strong presence.

There are these heroic people on the front lines ministering to people in their final weeks and days, a job that I can't even imagine doing frankly, day in and day out. Who would just have the most unbelievable compassion, but who will insist on never aiming at the death of the people that they encounter. Now they will, of course, insist on giving them very strong pain medication, tweaking their oxygen, making sure their nutrition and hydration levels, while not discontinuing them, are appropriate. But let's just be clear, the idea that those people don't have compassion is just totally ridiculous.

Ilora Finlay:

I think that we do the obvious thing to relieve human suffering, which is to say, what is the cause of the suffering?

PART 3 OF 4 ENDS [01:09:04]

Ilora Finlay:

...which is to say, what is the cause of the suffering? Break it down into its components. Look at each of those and say, "What can we do about this? How can we relieve it?" It is hard work. I may have spent hours with patients actually looking at what the problem is, what's going on, trying to understand it, and going out of my way/going the extra mile. On some patients, it would've been very easy to give in to just say, "Well, you're saying you want euthanasia." I think it's very easy to throw the towel in early. I think it's easy to stop thinking creatively. I've seen that happen in countries where I've sat in on consultations, and I've seen the ability to think creatively wane because the request for death is taken at face value. For the patient who is in distress... They don't believe that they can be out of distress until they are out of distress. I've had so many patients who say, "I never really believed that you would get my pain under control. I never really believed I could enjoy a day again."

John Dickson:

Baroness Finlay says she left general practice as a young doctor to become a full-time hospice doctor because she wanted to improve the care of the dying. Earlier this year, she was part of the push to amend the United Kingdom's healthcare legislation to make palliative care a legal right for the first time.

Ilora Finlay:

Palliative care aims to improve the quality of life of people with very, very serious illness and, as they are approaching death, to accompany them through that process and their family and support them. We neither hasten nor delay death. But we accept that death is a natural process. It's going to happen to everybody. But we deal with all of the aspects and not just symptom control but listen to people's worries, help them reset their hopes and aspirations, make sure that the family understand what's happening, help people fulfill their wishes to do things just through gentle, honest conversations and particularly support people pre bereavement and in bereavement.

John Dickson:

There's a mental health aspect of palliative care. It isn't just pain management.

Ilora Finlay:

No, it's definitely not just pain management. But Cicely Saunders, who was the founder of the modern hospice movement, coined the term total pain. That's really important because she pointed out that pain has got a physical stimulus. Yes, you must deal with that. But the way that you feel that pain, your pain experience, is altered dramatically by your, if you like, mental state. If you are frightened, worried, depressed, all those emotional things, you will feel your pain more. If you are worried financially, socially, worried about what's going to happen to the children when you die, you will feel your pain more because of that distress. Also, in those spiritual domains, the why-me, what-have-I-done-to-deserve-this, or perhaps feelings of guilt over something in the past that you've never disclosed to people, all of that will

make your pain experience worse. You don't, and you can't just deal with the physical. You have to deal with the psychosocial, the emotional, and even the spiritual domains if you are going to support people in getting their pain under control.

Melanie Lovell:

[inaudible 01:13:12].

John Dickson:

Hi, Mel, how are you?

Melanie Lovell:

It's nice to see you. I'm very well, thank you. Do you want to go straight across to the-

John Dickson:

Sure.

Melanie Lovell:

I thought we could just meet in my office.

John Dickson:

Yeah. Okay. Sure. I mean, it's weird being back.

Melanie Lovell:

Yeah. I knew it would be.

John Dickson:

Yeah. It just struck me as I turned up there.

Melanie Lovell:

Yeah. A lot happened. It's just a year ago. It's not long ago.

John Dickson:

To be honest, they were some of the happiest days.

That's my friend, Melanie Lovell, who happens to be an associate professor of palliative care at Sydney University and senior staff specialist and medical head of palliative care with HammondCare, one of Australia's leading palliative care and aged care providers. Mel met me at Greenwich Hospital in Sydney,

where my mate, Ben Shaw, spent about two difficult weeks toward the end before coming back home to die. But they were also very happy days.

I mean, we kept on getting in trouble from other staff going just, "Can you please keep-

Melanie Lovell:

[inaudible 01:14:13].

John Dickson:

...please keep it down? Please keep it down. Because when that Jolly Trolley came... I mean, you saw it. We had 10 to 15 people in Ben's room.

Melanie Lovell:

It was beautiful. It was so beautiful.

Oddly enough, being a palliative care specialist, I don't think a lot about death. I think a lot about living very fully every minute for the time you have. I don't feel like I'm surrounded by death all time. I feel like I'm surrounded by life.

John Dickson:

The expression "dying with dignity" is really owned by the euthanasia advocates now. But what for you is dying with dignity?

Melanie Lovell:

Dying with dignity is what it is for the person themselves. Everybody is different. Some people will prefer to die in hospital. Some people prefer interestingly to have very minimal symptom control and be-

John Dickson:

Awake, aware sort of thing.

Melanie Lovell:

Yeah. I mean, we aim to achieve people to be awake and aware with good symptom control. But some people don't want to have any medication for all sorts of reasons. Now that's hard for me to see, not the absence of medication but the presence of symptoms. But if that's what's important to them, then so be it, as long as we've addressed all the potential fears and made sure that they're not unrealistic fears that are causing them to have that. Dying with dignity is for the person to achieve death in the setting in which they wish, with their symptoms controlled and with them being really heard, their deepest concerns being heard and addressed as far as possible.

John Dickson:

Mel is a pain specialist. She's chief investigator on a number of clinical trials of medicines and non-pharmacological strategies for cancer, pain, and other symptoms, as well as the chair of the Pain Node of Palliative Care Clinical Studies Collaborative and Cancer Symptom Trials Group. That rolls off the tongue when she says it. She knows that pain is a problem and a powerful argument for those who advocate for euthanasia.

Take Angelique Flowers, who died at the age of 31 from colon cancer. The Sydney Morning Herald reported after her death that Angelique had wanted to end her life peacefully and on her own terms. Instead, because euthanasia wasn't legal at the time here in New South Wales, "Her final hours were robbed of the dignity that she wanted as he died vomiting the contents of her bowels," The Sydney Morning Herald reports.

Are you saying you won't even put this person out of their misery? Why wouldn't you make exceptions for the extreme cases and assist them in their suicide?

Melanie Lovell:

Yeah. That's the strongest set of arguments for euthanasia. But the problem is that exceptions don't make good law, and exceptions don't apply to a society. Yes, that can happen, that people can vomit up their own faeces if they have a very low bowel obstruction. It's awful. There's no two ways about it. It is awful. But we can do our best to relieve symptoms. There's lots of great ways of actually alleviating exactly that symptom and manage it as best we can.

John Dickson:

How good is pain management now? Are you confident it's getting better all the time?

Melanie Lovell:

Yes. Pain management is good, and pain still exists. It's a problem. There is improvement yet to be made. There's no two ways about that. One of my roles is chair of the pain group, the national and international Clinical Studies Collaborative in Palliative Care, and the Cancer Symptom Trials Group. I do get to see what's happening within pain. I do get to see, interestingly, as we get better at managing disease, people often have now multiple pains because they accumulate pains through the course of disease and treatment, treatment-related pains, as well as disease-related pains. But pain can be managed. I often see the most complicated of the pains because that's my area of interest and expertise. It can be managed. All the time, we're trialling new medicines for pain, as well as very importantly, new non-pharmacological strategies for pain.

John Dickson:

Like?

Melanie Lovell:

We've just done a really nice introductory study around virtual reality for pain. We found really good outcomes for that. There's great evidence around a whole set of meditation, mindfulness, relaxation, and even around exercises such as with gratitude and acceptance and so on for improvement in pain: exercise, massage.

John Dickson:

As you were talking, I was remembering Ben and his couple of weeks here. The foot massage person that came around daily... Ben would light up. For some reason, it helped his face pain.

Melanie Lovell:

Yes. Yeah. Exactly.

John Dickson:

That's weird.

Melanie Lovell:

Yep.

John Dickson:

Is that just taking your mind off it, or is there something more profound going on?

Melanie Lovell:

Such a great question. Yeah. There's two things going on there. Distraction is a powerful analgesic. But also, what you're doing is downregulating our central mechanisms. We have the ability to centrally, as in from our brain, inhibit pain. The things that inhibit pain are confidence, relaxation, and so on. Things that stop our central inhibition of pain are anxiety, depression, fear, that sort of thing. Massage and other techniques really start to engage that central inhibition of pain in a very powerful way.

John Dickson:

Yeah. Well, we saw it every day. Is it possible to die of a chronic painful illness, like pancreatic cancer or think of Ben's head tumor in a dignified way?

Melanie Lovell:

Oh, absolutely. Absolutely. That's important to many people. It's extremely important to us. Dignity is about having good symptom control. It's also actually about what dignity is to that person. They might want to die, as Ben did, at home. People might want to die surrounded by family and friends. People

might want to die in a certain way. We can enable that: not by ending life but by creating the space to help them achieve what they want to.

I have a passion for relieving suffering. I really don't believe that euthanasia is a way that you can relieve suffering. I believe that strongly. The reason is that I have seen people come to me with high-symptom burdens, high-level of distress. When I ask them, "What's important for me to know about them?" They might say, "I am committed to having euthanasia when the time comes. I'm committed. I'm a member of Exit International." But when I talk through with them what's actually causing their suffering, we talk about an approach to it. We talk about the fact that I will be with them, and my team will be with them throughout the process of their living and, ultimately, their death. The symptoms are just relieved. People feel so much more at peace, even if they are committed to euthanasia.

I think I've just seen so many people say, "I'm ready to..." Not I'm ready to die, but, "I want to die. I want my death hastened," but then change their mind. I have this sense that when people suffer and then ask for euthanasia, if they were to be euthanized, at that time, their suffering would never be relieved. They'd die suffering as opposed to have their suffering relieved.

John Dickson:

Let's press pause. I've got a five-minute Jesus for you. In his parable of the Good Samaritan, Luke 10, Jesus tells how a Jewish man was robbed and left for dead on the road between Jerusalem and Jericho, an ancient road you can still walk today. A temple priest walks by, he says, unwilling to assist. A Levite, who's a priestly assistant, does the same. Then a Samaritan turns up. These were considered the cultural enemies of Jews. He stops and cares for the man. He washes his wounds with oil and wine, bandages him up, pays for lodging in a local inn, and then returns later to check on the patient and to pay for any further expenses. Jesus ends the parable by saying, "Go and do likewise."

This is more than a picture of our spiritual need of Jesus as if we're the patient and he's the good Samaritan. The story inspired a massive medical tradition. There are tons of hospitals in the world today with the word "Samaritan" in it. It's got a lovely, modern resonance. But it's had that resonance from the beginning of church history. This particular teaching of Jesus, with its explicit reference to ancient medicine, washing wounds with oil and wine, inspired a huge healthcare movement in early Christianity.

The first public hospital we know of, I'm sure I've told you about this before, was established in about the year 370 by Basil the Great in Cappadocia, modern central Turkey. As bishop, Basil employed live-in medical staff who cared for the sick, drawing on the best traditions of secular Greek medicine. There were six separate departments, one for the poor, another for the homeless, a house for orphans and foundlings because the church in the fourth century was still collecting exposed infants, a completely separate section for lepers, rooms for the aged and infirm, and a hospital proper for the sick.

This idea caught on quickly. In the sermons and treatises of clergy, practicing medicine came to be regarded as the epitome of love of neighbor. The reasoning was pretty simple. The church couldn't quite heal the sick miraculously as Christ had done in the gospels. But the church could follow the Lord's example by using the resources it did have: money. Buildings, physicians, and volunteers. Official Canon

law made clear that local bishops were duty-bound to maintain facilities and staff to care for strangers, the poor, and especially the sick. There were literally thousands of hospitals from Jerusalem to France by the year 700. They were all church-run.

Hospitals were a central part of the idea of a Christian city. They were never for ending life, always for washing wounds and seeking to restore, just like in the parable of the Good Samaritan. These ancient hospitals were a fitting tribute to the fusion of classical Greek learning and Christian compassion. The knowledge and technology for these medical facilities came from pagan Greek tradition, from Hippocrates to the second century AD physician Galen. The inspiration for opening these facilities to everyone, rich and poor alike, came from Christian bishops like Basil and Christian emperors like Justinian, who saw such charitable services as just following the life and teaching of Jesus Christ.

The words "go and do," likewise, from the parable of the Good Samaritan, not to mention the self-sacrifice of Christ's crucifixion itself, loomed large in the minds of these ancient medically-minded Christians. A lovely Testament to this blend of ancient Greek medicine and Christian charity is found in the discovery of a thousand-year-old Greek manuscript of the Hippocratic oath, the one we quoted earlier. This particular manuscript copies out the ancient pagan medical oath in the shape of a cross. You can go and see it in the Vatican Library today if you're interested. Elite pagan knowhow, shaped and fuelled by the Christian ethic of love... It was the perfect combination, and it remade our world. You can press play now.

What vision of the good are you wanting to put in the place of the perceived good of assisted dying?

Charles Camosy:

Well, it's something we've hinted at already, and be good to say directly. It's a vision of the good, frankly, motivated by my faith. I believe what makes us all we, what makes the we, is being fellow members of the species homo sapiens created by God in God's image and likeness. Without reference to our autonomy, rationality, self-awareness, any capacity at all, that's what makes us, that's what makes us the community of right-sparing creatures under the law. That vision, in part, due to secularization, but, though, I think Christians who sold out to a different vision of the good also played a role, is being challenged directly by, again, of autonomy consumerist sense of what makes value and then nonviolence.

You add non-violence to that. That's another Christian commitment I have is... I don't know how people end up following Christ and end up arguing for violence. But I guess it happens sometimes. But I find it difficult to imagine and especially nonviolence in healthcare. The idea that healing and compassion, suffering with... including pain, medication including palliative care, super, super, super important, are all part of what it means to provide healthcare to somebody. But violence should never be part of what healthcare providers deliver, and killing, even under the auspices we're talking about, is violence and maybe the most important kind.

John Dickson:

If you made it to the end of this episode, then you absolutely deserve this hidden code to add to your entry to our epic 1000000th download competition running through August. Here's the code: EPIC. Head to undeceptions.com/million to find out what to do with it and for your chance to win awesome prizes.

If this episode wasn't long enough for you, we've released an extended version for our Undeceptions plus subscribers, which has more from all of Undeceptions guests, as well as Baroness Finlay and Professor Lovell's answer to my question about what euthanasia does to the doctor-patient relationship. It's fascinating.

Next episode, we're taking a look at some of the most common words of the New Testament and de-Christianising them: old-fashioned and daggy words like righteousness, salvation, fellowship. What in the world do these have to do with life today? Do we really even know what they mean? See you.

Undeceptions is hosted by me, John Dickson, produced by Kaley Payne and directed by Mark Hadley, editing by Richard Hamwi, social media by Sophie Hawkshaw, administration by Lyndie Leviston. Our online librarian is Siobhan McGuinness.

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