Euthanasia ? NO! (A.C.T.) Inc.
Email

SUBMISSION to

The Victorian Legislative Council’s Legal and Social Issues Committee Inquiry into

medical options available at the end of life

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Summary

It would be a serious reversal of public policy for the Victorian Government to be considering legalising changes to Victoria's legislative framework which would facilitate the deliberate taking of life. Though such changes often soften their true impact by characterising them as 'voluntary' euthanasia, careful consideration would conclude that 'voluntary' euthanasia is nothing other than assisted suicide whether the affected person is killed by another person or is provided with the means of killing him/herself.

Victoria, along with the Commonwealth and other Australian Governments, has made serious commitments over the past decade to promote and fund health programs which include the prevention of, or at least a reduction in the rate of suicide. Tragically suicide accounts for a large proportion of all deaths among young adults and other significantly vulnerable persons, such as those of indigenous background, men generally and particularly those in rural areas, and those suffering from mental illness including depression.

Legalising euthanasia would not be in the best interests of either Victoria or the Australian community as a whole. It would be a poor legacy for Victoria to be the first Australian State to legalise the direct killing of persons by medical staff or any other person; it would certainly fuel demands by pro-euthanasia advocates/publicists that the rest of Australia should follow with matching legislation.

Further, the enactment of such socially and morally significant provisions in any State/Territory would not be in the best interests for the practice of medicine in that area. Inevitably 'specialist' outlets would develop where the 'business' would not be expert diagnosis of a patient's condition nor referral to palliative care facilities, but rather death delivered as requested. It is a fact that experience in countries where euthanasia is legal, sych as the Netherlands and Belgium, 'involuntary euthanasia' leads to involuntary euthanasia for those persons deemed incompetent to make a choice for themselves.

Such an approach is in stark contrast to a principle which holds that vulnerable persons such as the depressed, those with physical or mentally disabilities, the frail aged and the dying should be given every assistance to cope with their situation without deliberate intervention causing death. It would not enhance the reputation of Victoria to become a euthanasia haven for those interstate patients who are experiencing difficulty in the management of their illness or those simply whose condition makes a bleak prospect of their lives.

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I. Suicide and public health policy – approach of Australian Governments

“Voluntary euthanasia’ is simply assisted suicide, a doctor usually the intended deliverer of the assistance. It would be perverse for any Australian Parliament to pass a measure facilitating assisted suicide in light of the Commonwealth’s and the States’ long-standing interest in, and active support of efforts to prevent suicide.

In 2004 the Commonwealth established the *New National Advisory Council on Suicide Prevention*; and subsequently in 2005 amended the Criminal Code Act 1995 (Cth) to include sections 474.29A and 474.29B, making it an offence to transmit, through telephone or internet, suicide related material with the intention, directly or indirectly, of counselling or inciting a person to commit or attempt to commit suicide.

In considering the provisions of the *Criminal Code Amendment (Suicide Related Material Offences) Act* 2005 the Senate Legal and Constitutional Affairs Committee called for the implementation of additional broader research, strategies, resourcing and policy initiatives by the Federal Government **and State/Territory governments in order to address jointly and consistently issues relating to suicide in Australia** (Recommendation 4). [bold added]

In July 2006, the Council of Australian Governments agreed, through the *National Action Plan on Mental Health 2006 – 2011*, to improve mental health services through promotion and prevention programmes, including suicide prevention.

In June 2010 the *Senate Community Affairs References Committee’s Report: The Hidden Toll: Suicide in Australia* recommended an economic assessment of the cost of suicide and attempted suicide in Australia and the development of a national suicide prevention and awareness campaign. The campaign was to include a targeted approach to high-risk groups, in particular young people, persons in rural and remote areas, men, and indigenous populations. Through cooperation with business and community groups the aim was to reduce the suicide rate by 2020.

In 2012 the Australian Government responded to the Senate Report, agreeing to support measures to reduce the damage suicide causes, noting that more than 2000 Australians take their lives every year – a tragedy for individuals, for families, for communities and for the whole nation. Acknowledging that the causes of suicide are numerous, issues such as isolation, disengagement, or instability in employment, housing, financial stress or personal relationships, the Australian Government increased funding of the *National Suicide Prevention Strategy* (NSPS), from $8.6 million in 2005–06 to $23.8 million in 2010–11.

Before the 2010 election the Prime Minister, the Hon Julia Gillard MP, committed the Australian Government to redouble its efforts to prevent the tragedy of suicide, making clear that mental health is an important part of her Government’s second term agenda and announcing a $274 million *Mental Health: Taking Action to Tackle Suicide* package, in an agreement with **State, Territory and local governments to set a target to reduce the suicide rate by the year 2020.** [bold added]

The opening words of the House of Representatives Standing Committee on Health and Ageing in 2011 are worth quoting:

> “Every year in Australia suicide claims the lives of around 2000 Australians placing it ahead of road traffic accidents and skin cancer as a cause of death. For young people aged 15 to 24, it is the number one cause of death. ...... New, strong and ever growing community engagement with these issues now place **mental health and suicide prevention firmly on the national policy agenda for political parties** ..... (Foreword: Report on early intervention programs aimed at preventing youth suicide).[1] [bold added]

The 2012 Report of the Australian Government National Mental Health Commission stated:

> “[E]ven the most disadvantaged should be able to lead a contributing life. … enriched with close connections to family and friends, good health and wellbeing to allow those connections to be enjoyed, having something to do each day that provides meaning and purpose”.[2]

Noting estimates of over 65,000 reported suicide attempts in Australia each year, the Commission recommended a coordinated effort to “prevent and reduce suicides, and support those who attempt suicide through timely local responses and reporting”.

With access to the promotion of suicide through the internet now restricted by the provisions of that legislation, it would be regrettable if the law of a State were to assist facilitation of assisted suicide. To do so would be poor public policy and undermine the ethical foundations of Australia’s health services.

II. Suicide in Australia

Over the 10 years between 2001and 2010 there were 22,526 suicide deaths registered in Australia; this represents for 1.7% of all the deaths which occurred in this period. There were 2,361 suicide deaths registered in 2010, an annual number relatively stable over the period. Males were between 3 and 4 times more likely to die from suicide than females, with half of all suicides occurring between 33 and 57 years of age for males and between 31 and 56 years of age for females.[3]

Age groups where suicide accounts for a large proportion of all deaths are for people between 15 and 24 years of age and between 25 and 34 years of age. However the rates of suicide are comparatively lower for females compared with those for males, 13.4 deaths per 100,000 of the male population and 4.8 deaths per 100,000 of the female population.[4]

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[1] House of Representatives Standing Committee on Health and Ageing. Canberra July 2011 Canberra.. *Report on early intervention programs aimed at preventing youth suicide*.

[2] *A Contributing Life: 2012* (National Report Card on Mental Health and Suicide Prevention), page 6.

[3] Australian Bureau of Statistics, *Suicides, Australia, 2010* (cat. no. 3309.0, Table 3.1). The data on suicide in this publication is sourced from the ABS Causes of Death, Australia, 2010 (cat. no. 3303).

[4] ibid.

III. Suicide and the law

Legislators have a responsibility to protect the community, for the common good of all, even if this involves some interference in the interests of some members of the public. Moreover, the whole community has a responsibility to protect vulnerable people and to provide the best medical and social care.

The law also has an educative dimension. It is for this reason that aiding or abetting a suicide is illegal in every State and Territory in Australia. A number of organisations and individuals argue that, as suicide is no longer a crime, providing information to assist suicide and actively assisting persons to commit suicide should be lawful. But just because suicide is not a crime does not mean it is a public good that should be promoted or facilitated. Suicide was decriminalised because there was little value in prosecuting someone who was dead or who had attempted suicide. Suicidal people need help, not prosecution. But there is great value in protecting the general public from people who would facilitate suicide.

IV Legalised euthanasia in the Northern Territory

Advocacy for legalising voluntary euthanasia/ assisted suicide cannot be satisfactorily discussed without reference to the work and views of Dr Philip Nitschke, Australia's leading advocate of euthanasia. Dr Nitschke was a one-time Greens candidate in Northern Territory elections.

Early last year Nitschke became actively involved in the discussions of euthanasia in the Australian Capital Territory, defending his role in the operation of the short-lived *Rights of the Terminally Act 1995* (NT) (the ROTI Act).[5] He falsely claimed that applicants to be killed were assessed according to strict criteria and only 4 of 7 persons met these criteria.[6] In fact, all 7 applicants for euthanasia were deemed to meet the criteria; only four were killed during the period of operation of the ROTI Act as reported in *The Lancet*, a leading UK medical journal. This paper notes the "clear limitations of the gate-keeping roles of the medical specialist and psychiatrist in the ROTI legislation". The article also records that:

> Depression was a major factor in the Northern Territory's experiment with euthanasia. … Of seven cases studied, Case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management. [7]

The authors also admit that fatigue, frailty, depression and other symptoms contributed more to the suffering of the patients than any pain arising from their condition; yet these persons met the requirements of the then Northern Territory euthanasia law.

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[5] The ROTI Act was quashed by Federal Parliament in 1996.

[6] *Canberra Times* 4 February 2011, p10.

[7] Kissane, D, Street, A, Nitschke, P (1998), Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia. *The Lancet*, Vol 352, pp1097-1102.

V. The practice of euthanasia

This analysis of the management of euthanasia in the only enabling Australian legislation gives warning that, despite any apparently strict criteria of eligibility for being killed (by lethal injection in the case of the ROTI Act), the recorded outcomes and experience with legalised euthanasia provide evidence of the inevitable extension to include the depressed of any age, the aged frail, the physically handicapped or mentally ill, patients in coma, etc.

Pro-euthanasia groups cannot dissociate themselves from the activities of Dr Nitschke's high-profile advocacy of euthanasia and suicide. He has said that knowledge of suicide methods should be available to anyone who wants it "including the depressed, the elderly bereaved, [and] the troubled teen".[8] Further, the suicide pill "should be available in the supermarket so that those old enough to understand death could obtain death peacefully at the time of their choosing".[9]

Nitschke has written an activist's manifesto, demonstrating clearly that he is not reluctant to analysing the economic benefits of euthanasia. Noting that end-of-life care is expensive, Dr Nitschke observed that if voluntary euthanasia lopped a mere six months off the lives of ailing elderly, immense savings would result. Therefore he concluded euthanasia would be a good way to trim fat from government budgets:

> One can but wonder when a government will have the guts to stop digging the fiscal black hole that is their ever-deepening legacy for future generations. While the enabling of end-of-life choices will not fix the economic woes of the next 40 years, it would not hurt, given half a chance. So the next time you hear a government minister trying to argue why this or that payment or welfare program for single mothers or war veterans must be cut, counter their argument with their fiscal irresponsibility on end-of-life choices.[10]

Dr Nitschke also included prisoners among the potential beneficiaries, mooting voluntary euthanasia as "the last frontier in prison reform".[11]

Therefore the persistent campaign in all Australian States for the legalisation of euthanasia cannot be separated from its chief advocate, architect and practitioner, Dr Phillip Nitschke, who over many years has been has provide assistance, advice and materials to assist persons achieve that end. Beginning in 2007 the then Greens leader Senator Brown introduced a number of Bills seeking to return the power of legislating for euthanasia to the Australian Territories. Dr Nitschke keenly supported Senator Brown's various Bills; he hoped that success in any State would "put immense pressure on other States", the best chance of success being "Tasmania where you've got the Greens in coalition with Labor".[12]

Dr Nitschke's activities in particular and proposals generally throughout Australia to legalise voluntary euthanasia, that is, assisted suicide, stand in stark contrast to our national strategy to reduce the suicide rate.

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[8] US Online review 5 June 2001: An interview with Philip Nitschke, the other "Dr.Death".

[9] Ibid.

[10] Ibid.

[11] Nitschke, P., *Killing Me Softly: Voluntary Euthanasia and the Road to the Peaceful Pill. Penguin Books 2005.*

[12] Interview with Green Left Review, September 25, 2010.

VI. Medical practice in Victoria – role of palliative care

Further legal euthanasia would not be in the best interests for the practice of medicine in Victoria. Inevitably 'specialist' outlets would develop where the 'business' would not be expert diagnosis of patients' health nor referral to palliative care facilities, but delivery of death. In particular it would be a tragedy to have euthanasia legalised in Victoria which would quickly become the 'death tourism capital' of Australia.

If doctors were to actively assist patients to kill themselves, then another significant barrier to the acceptability of suicide would be removed. Consequently the role of, and provision for palliative care services would likely be reduced; euthanasia and assisted suicide have no appropriate place within the practice of true palliative care. Palliative Care, as defined by the World Health Organisation, is:

> "… an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:
>
> - provides relief from pain and other distressing symptoms;
> - affirms life and regards dying as a normal process;
> - intends neither to hasten nor postpone death;
> - integrates the psychological and spiritual aspects of patient care …"

Two key principles underline the difference between palliative care and euthanasia and assisted suicide:

- affirms life and regards dying as a normal process; and
- intends neither to hasten nor postpone death.

Supporters of morally ethical palliative care recognise that when a person is dying there is no obligation to unnecessarily seek to prolong that person's life by extraordinary medical interventions, nor to use supportive means that are unduly burdensome.

It is of concern that many commentators are ill-informed about the operation of the *principle of "double effect"* in medical practice**.** This principle refers to what generally happens in a medical situation where an action is undertaken (or not undertaken) as part of ethical palliative care practice, but which may also have the indirect effect of hastening the patient's death. Examples include: the withdrawal of corticosteroids when they are no longer controlling brain swelling and further prescribing would be futile; or an increase in the dosage of a medical opioid in order to try and control increasing pain. In such cases the actions are not undertaken deliberately to hasten a patient's death; they may, however, coincide with, or indirectly hasten a patient's death.

Palliative care cannot prevent all unpleasant symptoms in the end of life stage. Its practitioners certainly seek to control and prevent any pain that patients are experiencing and Australia is among the leading countries in researching new palliative care medications for both adult and paediatric palliative care. Much more, however, could be done by State, Territory, and Commonwealth Governments to ensure that such services are broadly available to rural as well as urban patients.

VII. Vulnerable people

Between 2001and 2010 there were 22,526 suicide deaths in Australia; this represents for 1.7% of all the deaths which occurred in this period.[13] That is more than the annual road toll of over 1500 deaths per year that we see regularly reported on the television news.[14] A study by the World Health Organisation (WHO) found that, despite there being almost one million suicides every year, suicide is a largely preventable public health problem if the right policies and interventions are in place.[15]

Unfortunately, however, a significant pool of young people consider suicide or self-harm. Some 7%-14% of adolescents will self-harm at some time in their life, and 20%-45% of older adolescents report having had suicidal thoughts at some time. Certainly there is a very high association between suicide in adolescents and depression. Psychological post-mortem studies of suicides show that a psychiatric disorder (usually depression, rarely psychosis) is present at the time of death in most adolescents who die by suicide.[16]

Significant risk factors overall for suicides are major depression, substance abuse, severe personality disorders, male gender, older age, living alone, physical illness, and previous suicide attempts. For terminally ill patients with cancer and AIDS, several additional risk factors are also present.[17] Given the high association between depression, a treatable condition, and being suicidal, it is important that depression is always considered when suicide is discussed. Depression is often missed or not treated properly.[18]

Despite the importance of depression in contributing to suicidal behaviour, it was reported earlier this year that Exit International's director Dr Philip Nitschke refused to seek expert opinion on whether those who approach him are suffering from depression, saying:

> I would say common sense is a good enough indicator. It's not that hard to work out whether you are dealing with a person who is able to make rational decisions or not.[19]

Such an attitude is ideologically resistant to what is known of depression. Depression is more difficult to detect than many other health conditions because those suffering the condition are often unaware of their illness:

> Unfortunately, because a common symptom of depression is a loss of insight and a feeling of hopelessness, depressed people usually have little understanding of the severity of their illness. They are often the last to recognise their problem and seek help. It is therefore critical that primary care physicians develop the skills to recognise depression in patients, particularly the terminally ill and elderly, whose depressive symptoms may be masked by coexisting medical conditions such as dementia and coronary artery disease.[20]

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[13] See footnote 1.

[14] Australian Transport Safety Bureau (2005), Road Deaths Australia: Monthly Bulletin January.

[15] Suicide huge but preventable public health problem, says WHO.. Media release for World Suicide Prevention Day - 10 September. World Health Organisation. Issued 8 September 2004.

[16] Hawton, K and James, A (2005) Suicide and deliberate self harm in young people. *British Medical Journal*, Vol. 330, pp 891-894.

[17] New York State Taskforce on Life and the Law (1994), page 12.

[18] Hitchcock Noel, P et al (2004), Depression and comorbid illness in elderly primary care patients: impact on multiple domains of health status and well-being. *Annals of Family Medicine*, Vol 2(6), pp 555-562.

[19] Pelly, M, A better option: the wait for a way out. *The Sydney Morning Herald*, March 19 2005.

[20] New York State Taskforce on Life and the Law (1994), When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context. New York State Department of Health, page 15.

Depression was a major factor in the Northern Territory's experiment with euthanasia, as it is a major factor in the problem of suicide. In a major review of the case notes of seven people who sought euthanasia in the Northern Territory there was evidence of inadequate consideration of depression:

> To what extent was the psychiatrist trusted with important data and able to build an appropriate alliance that permitted a genuine understanding of a patient's plight? In case 1, there was important background detail about the death of one child and alienation from another, which was withheld during the psychiatric assessment. These experiences may have placed the patient in a lonely, grieving, demoralised position: an unrecognised depression may have led to suicide.
>
> Four of the seven cases had symptoms of depression, including reduced reactivity, lowered mood, hopelessness, and suicidal thoughts. Case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management. [Philip Nitschke] judged this patient as unlikely to respond to further treatment. Nonetheless, continued psychiatric care appeared warranted.[21]

Such vulnerable young people could be pushed over the edge to their death by individuals or groups promoting suicide or legislation which provides for death to be delivered by the provision of lethal means to be either self-administered or delivered by medical staff.

Legislators should not compound the suffering of victims of depressive illness and of their families by encouraging suicide rather than providing the help they obviously need.

If it becomes routine to ask for assistance to die then this acceptance becomes a pressure on people to end their lives with the self-justification that they will ease the burden on family while ending their own physical and psychological pain. Fear of dependency and reluctance to burden family members are influential factors in making a decision to commit suicide.[22]

Euthanasia is not a civilised solution to illness, pain or depression. There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care. Persons who are clinically depressed may wrongly see themselves as terminally ill. To allow such persons to seek death undermines the protection of the law for vulnerable suicidal people. Legal euthanasia signals that sometimes people's lives are no longer of value and can rationally be extinguished with assistance - a dangerous notion.

A Church of England cleric wrote recently in the (UK) *Guardian* that the romanticisation of suicide in earlier times has been replaced by the equally unfortunate current tendency to over-expose 'celebrity suicide'. There was nothing glamorous about taking one's own life, wrote Father Giles Fraser of St Mary's Newington in south London, giving this advice:

> "... If suicide is on your mind, forget the existentialists and the poets. Phone a helpline. Go and see your GP. Talk to friends. Stop drinking. Misery is survivable. And hold fast to the belief that a brighter day will dawn."

This is the reasonable and compassionate response to a person's demand for assistance in committing suicide.

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[21] See footnote 10.

[22] Johnson, T (2003), Book review: Suicide and euthanasia in older adults: a transcultural journey. *Psychiatric Services*, Vol 54, pp 261.

The Australian experience with euthanasia shows that the significance of depression and psychiatric illness in euthanasia and by implication in suicidal people should not be underestimated. Legalising assisted suicide will not promote understanding of, nor improve the management of depressed persons.

VIII. Legal euthanasia in the Netherlands and Belgium

Official government reports, the *Remmelink Report* (1991), the *Van der Maas Report* (1995) and the *Onwuteaka-Philipsen Report* (2001), provide very detailed data regarding the practice of euthanasia in the Netherlands. The overall conclusion was that physicians intentionally kill approximately 1000 patients each year without each patient's request or consent, representing between 0.7-0.8 percent of all deaths in the Netherlands. In slightly less than half of all involuntary euthanasia cases, the patient had not discussed euthanasia with the physician nor expressed a wish to be relieved of suffering. Significantly, in 79 per cent of these cases, the patient was mentally incompetent. The *Remmelink* Report also revealed that slightly less than 5,000 patients were killed each year by terminal sedation without explicit request; some of these deaths were deemed likely to be instances of involuntary euthanasia.[23] Overall one in every 32 deaths in the Netherlands resulted from legal or illegal euthanasia.

Reports from the Netherlands show that the consent of the patient is not always obtained, demonstrating that no matter how drafted the legalising instrument 'voluntary euthanasia' inevitably becomes something else. Though consultation with a person wishing to be assisted to commit suicide was desirable, this was not always the case in the Netherlands:

> The physician also discussed the decision to perform euthanasia or assisted suicide with relatives of the patient in 75.5% of deaths in 2005 and with one or more colleagues in 87.7% of deaths. When life was ended without the explicit request of the patient, there been discussion about the act or a previous wish of the patient for the act in 60.0% of patients … In 2005, the ending of life was not discussed with patients because they were unconscious (10.4%) or incompetent owing to young age (14.4%) or because of other factors (15.3%).[24]

An extract from an article published in the *Canadian Medical Association Journal* on the practice of euthanasia in Belgium indicates similar problems with the practice of legalised euthanasia in Belgium.[25]

> The evidence is clear that where assisted suicide or euthanasia is legalised there are serious concerns over how legally permitted assisted suicide is applied. In addition,, Dutch pro-euthanasia groups are campaigning to further extend grounds for assisted suicide eg to people with dementia. In 2010 the Dutch parliament was to debate a measure to legalise euthanasia or assisted suicide for anyone over 70 who had "simply had enough of life".[26] It is hardly necessary to point out the dangers of such proposals where the target population might include widows and widowers overwhelmed by grief, those unwilling to face the frailties of extreme old age and so on. Here is also the danger of older persons being pressured to end their lives to the advantage of

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[23] Report of the Committee to investigate Medical Practice Concerning Euthanasia. *Medical decisions about the End of Life*. The Hague: Ministry of Justice and Ministry of Welfare, Public health and Culture 1991.

[24] Van der Heide, A. et al., *End-of-Life practices in the Netherlands under the Euthanasia Act*. New England Journal of Medicine 356; 19 May 10, 2007.

[25] Chambaere, K. et al., *Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey*. Canadian Medical Association Journal June 15, 2010 vol,182 no.9.

[26] *Daily Mail*.co.uk by Mail Foreign Service. 10 March 2010.

> their beneficiaries. It is perfectly credible that reports of elderly people in the Netherland are so fearful of being killed by doctors that they carry cards saying that they do not want euthanasia.[27]

Experience in European countries illustrate this inevitable 'rationale' for extension of assisted suicide. In the Netherlands a collection of 35 bioethics centres and institutions recently released a statement regarding the Dutch government's announcement that it would extend its euthanasia law to include children. While euthanasia has been openly practiced for two decades, it was only formalized in statute law in 2002. This law allows the killing of patients down to the age of 16; it is now proposed to lower the age to 12. Similar proposals are being considered in Belgium including the euthanasia of children without parental consent. Appeals have been made to the European Union to protect the basic human rights of children and newborns, where consent is not possible.[28]

Lausanne University has announced that it will allow doctors and nurses, in that hospital, to kill patients. The hospital's legal director, Elberto Cresbo, stated "We are not trying to encourage suicide but, at the same time as a hospital, we have to respect the wishes of someone who wants to die."[29] The erosion of medical ethics seems to follow swiftly the legalisation of killing by doctors.

A compelling legal analysis of developments following the legalisation of euthanasia is given in a paper demonstrating the inevitable slide from voluntary to involuntary euthanasia:

> In December of 2004, administrators at a Dutch hospital announced a new policy that would allow pediatricians to kill severely handicapped newborn infants. In early 2005, the Royal Dutch Medical Association revealed that it had asked the government to propose new rules to facilitate the killing of "disabled children, the severely mentally retarded and patients in irreversible comas." To foreign observers who have not been following developments in the Netherlands, these news stories may have seemed shocking. Modern, liberal democracies are supposed to protect the mentally challenged and physically handicapped, not kill them.
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> For those who have been paying attention, however, these latest news reports merely represent the next logical step3 in the Netherlands' quixotic attempt to regulate euthanasia.[30]

IX. Rejection of euthanasia by other countries

The overwhelming evidence accepted by parliamentary inquiries into euthanasia conducted in countries across the world is that it is dangerous to give someone the power to kill another person. Vulnerable people who are sick, aged or depressed are inevitably at risk of consenting to be killed rather than getting the help they need. In recent years legalisation of euthanasia or assisted suicide has been rejected in all major Western countries. On 21 April 2010 the Canadian Parliament rejected euthanasia Bill C-384 by 228 votes to 59.

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[27] *Telegraph*, United Kingdom, 22 April 2011.

[28] *LifeIssues Newsletter* 2 221 April 2006. www.lifeisues.net

[29] *The Guardian* 19 December 2006.

[30] Allen, M. L., *Crossing the Rubicon*: *The Netherlands' Steady March Towards Involuntary Euthanasia,* Brooklyn Journal of International Law 2006 31:2 535-575.

On 1 December 2010 the Scottish Parliament threw out the *End of Life Assistance (Scotland) Bill*. Dr Gordon Macdonald commenting on this rejection commented:

> The decision can be summed as a feeling that we have a duty to protect the wider public good from the demands of those who adhere to a radically self-focused view of personal autonomy. Hence many of the [Members of the Scottish Parliament] who voted against the Bill, although coming from no strong personal faith perspective, did so in good conscience because they felt that their primary duty was to protect the vulnerable from risk of exploitation and the pressure to end life prematurely as a result of feeling burdensome to family and friends.[31]

In January 2011 the French Senate defeated a pro-euthanasia Bill by170-142 votes.

X. Euthanasia and the churches

Many church leaders have expressed their opposition to making assisted suicide legal. Such opinions deserve close consideration as church institutions have historically been in the forefront of providing care to the sick and the dying. For example, in their 2005 consultation Draft on *Advanced Care Planning* the Australian Catholic Bishops' Committee for Doctrine and Morals and Catholic Health Australia said:

> 1.2 Catholic ethical and social teachings seek to preserve respect for human dignity at all stages of life, particularly when people are most vulnerable due to illness or disability. In upholding respect for the worth and dignity of each person, we recognise the obligation that each of us has to take all reasonable measures to care for his or her own health, and so to use all "ordinary", reasonably available, and not overly burdensome, forms of effective medical treatment. (*Code of Ethical Standards for Catholic Health and Aged Care Services* [Catholic Health Australia, 2001], I, 1).
>
> 2.11 No one may rightly direct or ask that an unethical medical decision be made with respect to his or her care. Since euthanasia is wrong in itself, it would be wrong to request euthanasia, that is, to request that life-sustaining treatment be withheld or withdrawn *with the purpose of causing death*. In any case, euthanasia and assisted suicide are illegal in Australia.
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> 2.12 On the other hand: "Patients have the moral right to refuse any treatment which they judge to be futile, overly-burdensome or morally unacceptable, and such refusals must be respected" (*Code*, II, 1.16). When a treatment is withheld or withdrawn because it is futile or burdensome the intention is not to end life. Given the continuing debates over euthanasia and the withdrawal of medical treatment, it may be helpful for people reflecting on their future medical needs explicitly to state that they do want ordinary, life-sustaining treatment to be provided unless and until it becomes futile or overly burdensome.

The distinction between treatments intended to relieve pain and discomfort and deliberate action to take life is critical. The former is good medical practice and includes consideration for a patient's choice to refuse any particular treatment; the latter is a denial of the medical principle of *Do No Harm* and makes the doctor an executioner.

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[31] Dr Gordon Macdonald is Parliamentary Officer for CARE for Scotland and Policy Officer for *Care Not Killing Scotland*.

In May 2006 moves to approve an assisted suicide proposal in Britain were strenuously opposed by the *Care Not Killing Alliance* which was formed by medical groups, organizations representing disabled people, and churches. Leaders of various faith groups wrote an open letter to all members of Parliament and the House of Lords. The groups, which ranged from Buddhists, Christians, Hindus and Jews, to Muslims and Sikhs, expressed their concern at the attempt to change the law and added that they held all human life to be sacred and worthy of the utmost respect.

Just prior to the parliamentary debate, Anglican Archbishop Rowan Williams of Canterbury, Cardinal Cormac Murphy-O'Connor of Westminster, and Chief Rabbi Jonathan Sacks wrote to British MPs, urging them to take steps to ensure adequate training is given to doctors and nurses to adequately treat such patients. They also asked that more centres of specialist palliative care be established. They noted that in countries where assisted suicide or euthanasia is legalized there are serious concerns over how it is applied.[32]

The Lords voted 148-100 to postpone the debate. The British Medical Association continues to oppose assisted suicide or voluntary euthanasia.

XI. Legal euthanasia - a slippery slope?

It is too easy to disparage as a slippery slope argument reasonable predictions of the consequences of certain laws and/or practices. Legal permission for doctors to directly kill patients with their permission has led to an extension of the concept of voluntariness. It is too readily argued that, if the competent are to exercise choice to relieve their distress, then why should the same freedom be denied to the incompetent? If distress or loss of will to live is appropriate for those who are elderly or afflicted with a terminal illness, why should relief be denied to the young and those suffering the burden of mental illness?

In 2001 Dr Nitschke said that he chose to restrict himself to helping the group of “terminally ill adults who are articulate, lucid and not suffering from clinically treatable depression”. However he signalled a shift in the same article. “Someone needs to provide this knowledge [of suicide methods], training or recourse necessary to anyone who wants (death), including the depressed, the elderly bereaved, [and] the troubled teen”.[33]

Following the quashing of the *Rights of the Terminally Ill Act 1995* (NT) Dr Nitschke became involved with highly publicised cases of suiciding persons who were not terminally ill. It began with Nancy Crick. After her suicide it emerged that Crick was not terminally ill - a fact Nitschke had not publicly revealed. Suicide deaths of other persons in relatively good health followed. These actions were portrayed by the euthanasia lobby as rational suicides.

The concept of rational suicide greatly expands the range of people at risk from euthanasia activists who would appear to offer death as the easy solution rather than appropriate treatment and assistance. The difficult question of how to help suicidal people avoid a self-destructive course will be left unanswered. The difficult question of how to help suicidal people avoid a self-destructive course will be left unanswered. People at risk would include those living in social isolation, those with physical disabilities or even persons crushed by debt or bankruptcy.

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[32] *The Times* 12 May 12 2006.

[33] Lopez, K J (2001), Euthanasia sets sail. *National Review Online*, 5 June. http://www nationalreview.com/interrogatory/interrogatoryprint060501.html

XII. Limits to autonomy

It is often asserted by pro-euthanasia advocates that to restrict assisted suicide is to restrict a person’s autonomy to take charge of their own lives. Autonomy of the individual is not an absolute right. What may appear like an exercise of choice in choosing assisted death is that these persons may be suffering depression which can foment suicidal thoughts.

The exercise of one’s person’s autonomy, especially as approved by law, will increase pressure on the depressed, the frail, the elderly, and the confused to request euthanasia. People in those circumstances often feel they are a burden on relatives and consuming too much of society’s resources. A law allowing euthanasia or assisted suicide, by legitimatising that option, removes the bulwark which should protect such persons from themselves and from those who might out of self-interest exploit their weakness.

During the debate on the Lord Joffe’s 2006 UK euthanasia provisions Jane Campbell, a Disability Rights commissioner, explained how she suffers from a severe form of spinal muscular atrophy. "Many people who do not know me," she commented, "believe I would be 'better off dead.'" This sort of view is based mainly on ignorance, or even prejudice, argued Campbell. Lord Joffe’s Bill failed to get the endorsement of a single organization of disabled people. Groups representing the terminally ill and disabled, frightened by what the Bill sought to achieve, formed a coalition, *Not Dead Yet*, to fight the proposal.[34]

Patient autonomy is not well served by legal euthanasia as was found in the Netherlands:

> In the end, the balance that the Dutch government has attempted to strike between patient-autonomy principles and physician beneficence has not succeeded. Their approach to euthanasia regulation does not protect vulnerable individuals from potential abuse, fails to provide physicians with incentives to comply with the statutory reporting requirements, and as a practical matter, fails to prevent involuntary euthanasia. Although the Dutch government speaks the language of patient rights, relief from suffering, and death with dignity, it has created a system in which physicians, not patients, control the circumstances of death.
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> Although the Dutch government speaks the language of patient rights, relief from suffering, and death with dignity, it has created a system in which physicians, not patients, control the circumstances of death.[35]

XIII. Conclusion

Palliative care is advancing very rapidly, both in relieving suffering experienced by those with a terminal illness, as well as in providing support for their families. Politicians should take steps to ensure adequate training is given to doctors and nurses to adequately treat such patients; they should also fund the establishment of centres of specialist palliative care. They should ensure that the law continues to affirm the principle that life is precious especially in its most challenged, vulnerable moments. The Attachment is an eloquent statement of these principles.

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[34] *The Guardian* 9 May 2006.

[35] See footnote 34.

Attachment

Odette Spruyt* *The Age* 5 February 2007

RECENT articles and letters after the death of Dr John Elliott have presented dying in Australia as a fearful and terrible experience. People are said to suffer not only physically but also a total loss of dignity such that desperate people have no choice but to take extreme measures.

Human dignity is presented as totally dependent on fragile externals. We lose our dignity in the face of suffering, be it physical, emotional or social. We lose our dignity if we lose control of our decision-making capacity, our bowels, our mobility, our mind. We lose our dignity if our loved ones can't or won't care for us and we refuse to let others do so.

The subversive practice of giving patients lethal doses of morphine is portrayed as commonplace and indeed necessary for pain-free dying within the constraints of what is inferred to be archaic, inhumane and ineffective health care for the dying.

I have worked as a specialist palliative care doctor for 13 years. The exposure to death and dying daily has taught me many lessons. When I read the story of Elliott, some apparent absences are disturbing: the absence of an extended care network, the absence of any mention of palliative care/pain management expertise, the absence of the will to live (portrayed as somehow heroic). This is one man's story. It is certainly not everyman's story.

In Australia over the past 10 years, there has been an impressive increase in the range of pain management drugs. We now have more than 10 strong pain killers (opioids) that can be given in many different ways so that finding the right drug for the individual is now possible. In addition, we have a vast array of supportive pain-relieving drugs that can be combined with the opioids, to safely minimise the dose of opioid and optimise pain relief. Combinations often achieve more than one drug alone but are more complex for the patient, carer and doctor to manage, hence the need for specialist palliative care/pain management assistance.

Added to the medications now available are many other treatments such as radiotherapy, specialised anaesthetic techniques for cancer pain relief (such as epidurals), neurosurgical techniques and anticancer treatments, which may reduce the tumour size and activity and so reduce the tumour-associated pain. We also have a national, free palliative care network, available to all, providing care for the dying in hospitals, hospices and at home.

It is simplistic to argue that palliative care can remove all suffering at the end of life. However, why is it that at a time of such greatly improved analgesia and systems of care, the envy of many countries worldwide, there appears to be such a great fear of dying in unrelieved pain and suffering? Our resources have never been better. Why are people being told that there is nothing to help them?

As a community, we do need a better understanding of palliative care as specialised health care for those approaching death. Palliative medicine is also not well understood by the medical community, which leads to ignorance in the use of analgesics, even by experienced doctors. For example, it is inaccurate to say that such large doses of narcotic analgesia as would suppress breathing and shorten life are necessary to relieve pain in the dying.

A recent review of hospice practice showed that the norm is modest doses of opioids in the final 48 hours of life. This is evidence that with best total care, extreme dosing is not required for a peaceful death and may in fact achieve the opposite due to side effects. In addition, such rhetoric reinforces the negative stereotypes that abound about the medical use of opioids and prevents many patients from accepting appropriate pain relief out of fear that these drugs will kill them.

However, perhaps it is not the fear of pain and suffering but rather a fear of death itself that drives this issue.

In fact the fear of death may be greater than ever before in our youth-oriented culture. Perhaps we need to slow down. In our rush to the finishing line, we are failing to see:

- The tireless devotion of a young wife for her dying husband.

- The marriage in hospital of a long-together couple two days before his mother dies.

- The exquisite intimacy and tenderness of a mother as she cares for her dying 20-year-old daughter.

- The laughter of families as they reminisce around the bedside of their father.

- The children doing puzzles on the floor of their grandmother's hospice room.

- The daily courage and dignity of the ill in the midst of incontinence, pain, tears and grief.

- The urgency in the steps of the nurses intent on relieving the pain and distress of their patient.

- The friendship and love which grows between staff and patients in the midst of adversity.

- Life renewing in the face of death.

We may crave for a way to circumvent the pain of dying, the grief, the loss and the seeming uselessness of it all. We may prefer a neater exit of our own time and choosing. However, we risk anaesthetising ourselves from life, and losing much of its richness, mystery, beauty and soul.

Instead of running from death, we need to embrace those who are dying within the community of the living and ensure that they know they are a vital part of life until their last breath.

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