

## Inquiry into End of Life Choices

“It is better for me to die than to live.” I believe that Victorians should be supported in their physical and mental health in any way but not via the final solution of euthanasia or assisted suicide. For those who are dying, we should embrace Palliative care. Sadly, not every Victorian has reasonable access to palliative care and there is more research to be done to improve palliative care.

With regards to access to palliative care, the findings of Palliative Care Australia advise that specialists should be provided to the level of 1.5 full-time-equivalent (FTE) per 100,000 people, the minimum ratio for a reasonable provision of service.<sup>1</sup> The Australian and New Zealand Society of Palliative Medicine says that 1.0 full time equivalent (FTE) palliative medicine specialist per 100,000 people, and they explain their reasons for a lower ratio in the document *Position Statement. Benchmark number of Specialists in Palliative Medicine*.<sup>2</sup>

In practice, palliative care services in Australia fall way under. The Australian Institute of Public Welfare 2013 report on palliative care services in Australia documented that the average ratio of FTE palliative care specialists nationally per 100,000 people was only 0.4. This varied between the states and then, furthermore, between the city (0.5) outer regional areas (0.3) and an even lower average in inner regional areas (0.2).<sup>3</sup>

More research is required within Palliative Care to relieve the burden of existential suffering. From Oregon, the first US state to legalise physician-assisted dying, it has been reported that the three most frequently mentioned end-of-life concerns were: loss of autonomy (91.4%), decreasing ability to participate in activities that made life enjoyable (86.7%), and loss of dignity (71.4%).” Inadequacy of pain control is always a lower concern.<sup>4</sup> Clearly the public trust the medical professional’s community to manage pain. More is to be done to manage loss of autonomy and the feeling of being a burden on family and friends.

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1. Palliative Care Australia (2003) Palliative Care Service Provision in Australia: A Planning Guide. Canberra: PCA.
  2. <http://www.anzspm.org.au/c/anzspm?a=da&did=1005077>
  3. Tables 7.3, Table 7.4 <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129545131>
  4. **Oregon Public Health Division Year 17 - 2014**, Released February 12, 2015  
<https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>

It is important to examine the seven people who died under the Northern Territory legislation during 1996-97 (Rights of the Terminally Ill Act ). We learn that legal and medical safeguards were overlooked. A leading expert in the NT experience, Dr David Kissane, psychiatrist and palliative care specialist published a report in 1998 which found that there were “difficulties in the assessment of depression and suicidal symptoms in terminally ill patients, particularly on a single clinical assessment, are well documented. Having taken the decision to kill themselves some individuals may seem less depressed than previously and the focus on pursuing assisted suicide may distract both the patient and the doctor from the underlying despair, fear, and helplessness.”<sup>5</sup>

Dr Kissane reviewed Nitschke's cases and made this assessment of the so-called "safeguard" of compulsory psychiatric assessment:

"Nitschke reported that all patients saw this step as a hurdle to be overcome. Alarming, these patients went untreated by a system preoccupied with meeting the requirements of the act's schedules rather than delivering competent medical care to depressed patients." <sup>6</sup>

Then there was Dr Nitschke's admission that he personally paid the fee for the psychiatric assessment of one of the patients he euthanized. <sup>7</sup>

Incidentally the “second opinion and consultation” safe guard was not universally applied in Belgium, the Netherlands, and Oregon.

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5. <http://www.lancet.com/journals/lancet/article/PIIS0140-6736%2805%2979938-4/fulltext?version=printerFriendly#bib2>

6. <http://www.theaustralian.com.au/national-affairs/commentary/unproductive-burdens-still-have-a-right-to-live/story-e6frgd0x-1226027674393>

7. Kissane DW, Street A, Nitschke P. Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia. *Lancet* 1998; 352: 1097-1102

Reading Oregon Health Divisions Annual Reports highlights the issue of those patients who do not die after ingesting prescribed medication. Reading the Annual reports one discovers that there is always a proportion of people who by no means could be said to have died with dignity.<sup>8</sup>

Another point to make about end of life issues is that Victorians should be reassured that they will not be forced to undertake extraordinary measures of preserving life. Acclaimed ethicist Margaret Somerville makes the point :

*That's what I call legalising euthanasia through confusion because what the argument that's being put there is that there is no difference between letting a person refuse treatment to allow them to die and they die of natural causes. If they've got no underlying diseases, if you take away the treatment, they won't die. As compared with when you give them something to kill themselves (which is assisted suicide) or you give them a lethal injection (that's euthanasia) and you, the other person, is assisting in, or doing, the killing. And the law makes that distinction ALL the time...<sup>9</sup>*

The “slippery slope” is a simple way to explain the phenomenon of where poor public health decisions lead. In the Netherlands over thirty years of euthanasia, we have witnessed it progress from being limited to terminally ill, competent adults experiencing unrelieved pain. Nowadays, none of those requirements apply. The Groningen protocol allows parents of disabled babies to request euthanasia; children can request euthanasia.

Perhaps we should not take for granted that the code of conduct for all professions clearly excludes killing. Let's invest our “end of life” resources in palliative care.

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## 8. Death with Dignity Act Annual Reports

<https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx> ]

9. “Assisted suicide in Canada” Published Jul 2012. A panel discusses the B.C. Supreme Court judge's decision to strike down parts of Canada's law banning the practice.

[http://www.youtube.com/watch?v=uBku\\_nSIoNM](http://www.youtube.com/watch?v=uBku_nSIoNM)

## Further Reading

1. Evidence from euthanasia advocate Dr Philip Nitschke himself during the 1997 Euthanasia Inquiry into the ACT's Rights of the Terminally Ill Act. Philip Nitschke in giving evidence at an inquiry, told them about the instance of a 20 minute psychiatric consultation:

“...So maybe it was a breach but it was a breach that was motivated...by compassion.”

Testimony to the Tasmanian Joint Standing Committee on Community Development Inquiry into the Dying with Dignity Bill 2009 (2009, August 31 ) pp. 112-113  
<http://www.parliament.tas.gov.au/ctee/Transcripts/31%20August%2009%20-%20Hobart%20dwd.pdf>

2. Dr. José Pereira worked for three years as a palliative care physician in Switzerland at a hospital where assisted suicide was practiced “Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls” J. Pereira Current Oncology Vol 18 No 2 (2011). <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3070710/>