

Dear Hon Edward O'Donohue,

I am writing to express my thoughts and beliefs in regards to end of life choices, specifically euthanasia.

***Euthanasia:*** “An action or omission which of itself and by intention causes a person’s death with the purpose of relieving suffering (actual or perceived)”

In accordance with the Universal Declaration of Human Rights (United Nations, 1998) all people have certain inalienable rights. The first and most fundamental of these rights is the right to life. Important to this definition is that “inalienable rights” are rights intrinsic to the human person - that is no state, group or individual may deprive of those rights and indeed one may not deprive themselves of those rights. It is in the interest of both the state and the individual to uphold these rights.

Consider the situation in which a man wants to sell himself into slavery for the sake of his impoverished wife and children. Despite the reasons for his voluntary cessation of his right to freedom the state would never condone such abrogation of human rights. Firstly it is not in the interest of the individual themselves, as there are better solutions to selling oneself into slavery. Secondly, in a world where inviolable, inalienable rights may be voluntarily seceded, human beings will inevitably be involuntarily violated in other cases. In the same way one may want to end their life because of difficulty or suffering. The state should never support either killing or suicide. This is because it is not in the interest of the individual and there are better ways of dealing with suffering.

While individuals may have the ability to sell themselves into slavery or end their own lives it does not mean that they would or should have a state sanctioned right to do so. In fact we see very significant efforts by public bodies to mitigate the issues of both slavery and suicide.

The alleged right to die is a misnomer and one that holds dangerous and often unrecognised consequences. The consequences of a right to die were best explained by Dr Phillip Nitschke in June 2001: “If we accept there is a right to life, then we must accept that people have a right to dispose of that life whenever they want...including the depressed, the elderly bereaved and the troubled teen”. Clearly the right to freedom does not necessitate a right to slavery and similarly a right to life does not necessitate a right to death, rather it contradicts it. Furthermore this statement draws into sharp relief the targets of euthanasia, namely the most vulnerable in our society such as the elderly, the sick and those with mental illness.

In both Belgium and the Netherlands studies of euthanasia have consistently demonstrated that the existing legal constraints have categorically failed. In Belgium 5.4% of all deaths in 2007 were by euthanasia. 32% of these were without explicit request from the patient (1.8% of all deaths). The vast majority who die without explicit request were not competent, with 70.1%

being comatose and 21.1% of cases having dementia. In 60.6% of these cases the patients had **never** expressed a wish to end their lives (Chamberae et al, 2010).

More concerning are the changes in other end of life practices, particularly deep-continuous sedation (DCS). Deep continuous sedation is a protocol of sedation and cessation of hydration, nutrition and all other medical care. From 2001 to 2007 the rate of DCS use in death rose from 8.2% to 14.5% of deaths. Similarly in the Netherlands DCS increased from 5.6% in 2001 to 12.3% in 2010. The introduction of euthanasia in the Netherlands has fundamentally altered the way doctors interact with patients, in which killing patients has become one of the viable options of “care”. The authors of the Belgian study state that the demographic group of patients euthanased *without explicit request* “fits the description of vulnerable patient groups... patients with disease other than cancer, which have an unpredictable end-of-life trajectory”. (Chambaere et al, 2009)

Furthermore based on responses from 3,623 questionnaires it was found that 52.8% of the euthanasia deaths in the the Flanders region of Belgium were reported while 47.2% were not (Smets et al, 2010). They found that most of the euthanasia reported was in compliance with the law but the majority of those not reported were not. Doctors gave reasons for not reporting a death as euthanasia including denying the act as euthanasia. This was due to either the administrative burden that ensues with euthanising, or because legal requirements had not been met.

### **The Disabled and Young**

The Groningen Protocol was developed in Netherlands in order to assist with the decision making process when considering actively ending the life of a newborn, by providing the information required to assess the situation within a legal and medical framework. All cases between 1997 and 2004 concerned newborns with spina bifida and hydrocephalus. These practices are a manifestation of the fact that when a society deems certain forms of human life not worthy of life, then all lives are at risk, particularly disabled children.

### **The Mentally Ill**

The position of many euthanasia advocates, including Philip Nitschke, is that intractable and intolerable mental suffering should be criteria for euthanasia and PAS. The 2013 Euthanasia report from the Netherlands indicated there were 42 euthanasia deaths for psychiatric reasons and 97 euthanasia deaths for people with dementia in 2013. Indeed the medical registration of Phillip Nitschke has been suspended for assisting in the suicide of an otherwise healthy 45 year old Perth man (Chalkley-Rhoden, 2014).

In Oregon, USA, Physician Assisted Suicide was legalised in 1997 and the state has since seen radical changes in its overall suicide prevalence. Overall Suicide rates among adults ages 45-64 rose approximately 50 percent from 18.1 per 100,000 in 2000 to 27.1 per 100,000 in 2010, 41% higher than the national average (Shen, X., & Millet, L., 2012). Amongst those who do receive Physician Assisted Suicide there are very poor rates of psychiatric referral, with 0 in 85 patients

being referred in 2007 and in the years prior to that only 12.6% receiving referral (Steinbrook, 2008). Even in the cases of psychiatric referral only 6% of psychiatrists reported confidence that a single assessment could enable them to decide whether or not mental illness is influencing a person's request. (Ganzini, 1996)

### **The Doctor-Patient Relationship**

A review of the literature on current legal euthanasia practices elucidates just how the legalisation of euthanasia perverts the doctor-patient relationship. Whereas the demented patients or mentally ill individuals ought to be offered quality care and genuine compassion, instead they are offered lethal pharmaceuticals. There are two particular perversions in this relationship. The first one is that the patient often makes their decision for euthanasia based on the physician's prognostication e.g. the patient may opt for euthanasia if they are told they have 12 months to live and life may be painful. More often than not Doctors predictions on lifespan and disease experience are wrong, meaning that patient decisions will be misinformed. However, unlike most patient decisions there is nothing that can be done even if that were somehow known to be the case. More significantly, euthanasia requires doctors sanctioning the patient's belief, to some degree, that some lives are not worth living and warrant termination. This concept is one necessary to any euthanasia and explains the facile development of involuntary euthanasia from its voluntary counterpart.

### **Palliative Care**

For those populations of terminally ill patients who are held up as examples as to why we need euthanasia, there are always better options in palliative care and supportive medicine. The Australian College of Palliative Care Specialists has a clear position on Euthanasia; "Palliative care is aimed at supporting people at the end of their life, and this never involves an intention to end a patient's life."

Palliative care provides genuine physical, emotional and spiritual care to meet the needs of the suffering patients. Good palliative care can often ameliorate or eliminate the patient's desires for euthanasia and is comprehensively consistent with the core tenets of modern medical practice. Euthanasia perverts and takes away from the practice of palliative care in particular, because it requires those same people offering care in the final stages of life to also offer killing.

### **Concluding Note**

The 1994 British House of Lords **Assisted Dying for the Terminally Ill Report Committee** initially had half of its members as strong euthanasia advocates. Upon visiting Holland they heard of an alarming number of patient deaths without patient consent, and were openly told by Dutch advocates of euthanasia that "***effective safeguards against abuse had proved impossible to devise.***" This Committee issued a unanimous report rejecting legalisation with a final statement saying "***To create an exception to the general prohibition of intentional***

***killing would inevitably open the way to its further erosion whether by design by inadvertence or by the human tendency to test the limits of any regulation.”***

This view has only been corroborated by the ongoing research from places like Belgium and The Netherlands. Ultimately it is the strong evidence base against euthanasia that belies its repeated rejection by the World Medical Association, the Australian Medical Association and the Australian Government.

Euthanasia devalues human life, it is dangerous for doctors and is dangerous for patients. It should not be legalised in Australia.

Thank you for taking the time to read my submission.

Yours sincerely,

Matt Donnelly

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