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## **SUBMISSION CONTENT:**

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I have been a specialist in Palliative Medicine over three decades; I am a Life Member of the Palliative Care Council, and achieved an MD by published work.

### **THE CRITICAL QUESTION: MURDER VERSUS MERCY?**

Under existing law, if a doctor intentionally and compassionately hastens a patient's death, upon the patient's request to end their suffering, that doctor can be prosecuted with the most serious of crimes – murder.

Is this a just law? If you answer 'No . . . the doctor should not be charged with murder', then you favor law reform for voluntary euthanasia (VE). If you say 'Yes . . . the doctor should be prosecuted for murder', then you are against VE law reform.

Surveys of Australians over the past few decades consistently show that around 80% believe a person with terminal illness should have a legal option for VE to end their suffering. [1] About 50% of doctors favor law reform. [2] Curiously, it seems palliative clinicians and parliamentarians have the lowest level of support.

I came into palliative medicine with no fixed position on VE, but as I witnessed the suffering of patients, and listened to their wishes, some pleaded rationally with me to hasten their demise. I progressively formed a view in favor of VE reform.

In this short article, I will examine some of the major myths about VE. I will allude to published evidence, including from jurisdictions where either VE or physician assisted suicide (PAS) has been legalized (The Netherlands, Belgium, Luxembourg, Switzerland, and USA – Oregon, Montana and Washington).

### **MYTH: SUFFERING CAN BE PALLIATED SO THERE IS NO NEED FOR VE**

In reality, it is impossible to relieve all suffering, such as fatigue and dependency, or eliminate symptoms

caused by failing organs, or to change peoples' long-held beliefs about their end-of-life wishes.

Dying people have varied and sometimes intense suffering, including physical, emotional, and existential suffering. All surveys of palliative patients, including those in most renowned hospices, show they experience multiple concurrent symptoms. Severe refractory symptoms, including suffocation, pain, nausea and confusion, requiring palliation with deep sedation, have been reported in up to 50% of palliative care patients. [3]

Also, surveys show 5 to 10% of patients with advanced illness request a hastened demise, and this proportion is actually higher in patients who receive hospice care. [4,5]

In the VE debate, many palliative specialists have difficulty hearing and representing the wishes of their patients who want VE, and difficulty appraising the relevant literature. Does some ideology (perhaps medical or religious) impede their ability? Do they fear being personally involved in VE? Why do they view VE as antagonistic to palliative care?

#### MYTH: VE LEGALISATION WILL UNDERMINE PALLIATIVE DEVELOPMENT

In fact, the opposite occurs - when VE legislation is introduced, palliative care is boosted. For example, in the Northern Territory, as a consequence of debate about The Rights of the Terminally Ill Act, the world's first VE legislation, the NT palliative care service gained the highest per capita funding in Australia. In Oregon, where PAS was enacted in 1997, palliative referrals increased, markers of end-of-life care became among the best in the USA, and over 90% of those who accessed PAS also had hospice care. [6,7]

When VE reform is being considered, the importance of palliative care becomes obvious to parliamentarians and health care administrators, so its development is naturally enhanced rather than undermined.

#### MYTH: SANCTIONING VE CREATES A 'SLIPPERY SLOPE'

This argument suggests doctors will develop a 'lust for killing', that 'a culture of death' will grow, and vulnerable people will increasingly be pressured to die, or be killed against their wishes (a bleak view of humanity!).

Data from more and more jurisdictions, however, indicate the 'slippery slope' is a myth. For example, in the Netherlands, 1.7% of deaths involved VE in 1990, and in 2005 it was the same (1.7%). [8] In Oregon, where 0.2% of all deaths involve PAS, it is educated rather than vulnerable persons who access PAS. [6,7]

Interestingly, surveys in countries that have yet to sanction VE or PAS have higher rates of (covert) voluntary and non-voluntary euthanasia. For example, a survey of Australian medical practice revealed 3.5% of deaths involved 'ending life without explicit request', whereas the comparable figure in The Netherlands was 0.7%, and by 2012 this had decreased to 0.2%. [9]

Also, a survey of Australian surgeons revealed one third had given medications with the intention of causing death, often without request (if the criminal law was thoroughly enacted, there would be a lot of Australian surgeons in prison!). [10]

This raises the possibility that visibility (through reform) may be the best way to protect vulnerable patients.

#### MYTH: VE WILL HAVE NEGATIVE EFFECTS ON THE DOCTOR-PATIENT RELATIONSHIP

It is the role of the doctor (conferred by society) to be involved in life-and-death decisions. It is routine for doctors to withdraw and withhold life-prolonging treatments, and to administer medications to relieve suffering, even if death is hastened. Similarly, people want doctors to assist them with VE and PAS.

Doctors in Oregon were more likely to receive an explicit request for assisted suicide if they found caring for a dying patient ‘intellectually satisfying’, if they sought to improve their knowledge of pain control in the terminally ill, and if they were willing to prescribe a lethal medication. [11] Those who opposed PAS were twice as likely to report patients becoming upset, or leaving their practice, as a result of their position compared with physicians who supported PAS. [11]

We should aim to satisfy the wishes and interests of every patient, and to do our best for each individual that seeks medical help. I think this is why some doctors flout the criminal law, at great risk to themselves, to covertly provide VE for patients in unbearable suffering who plead for such help.

## MYTH: VE IS UNETHICAL

Opponents portray VE as a form of immoral killing, yet there are differences between murder and VE, just as there are differences between rape and making love. A valid moral appraisal must take account of the wishes of the subject person, the motivation of the act, and its overall context.

Personal liberty underpins VE - the ability of an individual to make an autonomous choice about the end of their life. Autonomy is not invalidated because a person is suffering.

VE also requires an act of conscience by the doctor, whose motivation should be compassion and mercy, to help the person who requests a quick death to end suffering.

## CONCLUSION

The overwhelming majority of people want to have a choice about ending their life, should they be suffering with terminal illness. However, the proportion of people with terminal illness who actually want to end their lives with VE or PAS is quite small.

Palliative specialists cannot eliminate all the harrowing indignity and disintegration of dying, and should acknowledge the persistent and rational wish of some patients for a hastened demise. Sanctioning VE will promote palliative care; it does not create a ‘slippery slope’, nor undermine the doctor-patient relationship. It is misguided paternalism that denies patients a choice; it is a lack of mercy that mandates suffering; and it is an unjust law that puts doctors at risk of serious prosecution.

VE/PAS empowers terminally ill patients with a reassuring choice for a quick exit if their suffering is too great to bear. I am confident the medical profession in Australia will be responsible, careful and considered in the care of patients who request such help to die.

## References

- [1] Morgan Gallup Polls in response to the question: ‘If a hopelessly ill patient, in great pain with absolutely no chance of recovering, asks for a lethal dose, so as not to wake again, should a doctor be allowed to give a lethal dose, or not?’
- [2] Medical opinion – Dying with Dignity NSW. [dwdnsw.org.au/medical-opinion/](http://dwdnsw.org.au/medical-opinion/)
- [3] Cherny N, Portnoy R. Sedation in the management of refractory symptoms: guidelines for evaluation and treatment. *J Pall Care* 1994.
- [4] Hunt R, Maddocks I, Roach D, McLeod A. The incidence of requests for a quicker terminal course. *Palliative Medicine* 1995, 2; 167-168
- [5] Seale C and Addington-Hall J. Euthanasia: the role of good care. *Soc Sci Med* 199. (English study of 639 people dying in 1987 and 3696 in 1990).
- [6] Oregon Death With Dignity Act, 2012 Annual Report. <http://www.healthoregon.org/dwd>.
- [7] Legal Regulation of Physician-Assisted Death — The Latest Report Cards  
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- [8] Van der Heide et al. End-of-Life Practices in the Netherlands under the Euthanasia Act. *N Engl J Med*

2007; 356; 1957-1965.

[9] Kuhse et al. End-of-life decisions in Australian medical practice. MJA 1997, 166; 191-196

[10] Douglas CD et al. The intention to hasten death: a survey of attitudes and practices of surgeons in Australia. MJA 2001.

[11] Ganzini L et al. Oregon physicians' attitudes about and experiences with end-of-life care since passage of the Oregon Death with Dignity Act. JAMA, 2001; 18; 2363- 2369.

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