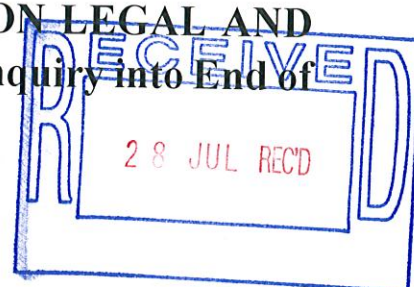


Submission to the STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES (Legislation and References) Inquiry into End of Life Choices

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I submit my credentials (appended) as a person able to speak with long experience in the care of patients with advanced cancer in their last days or weeks.

At the outset I want it to be clearly understood that in opposing euthanasia and assisted suicide I am opposing the direct intentional killing of another human being or assisting in their suicide.

I do not oppose but vehemently support the withdrawal of measures which would only prolong the act of dying, such as the use of futile antibiotics, intravenous lines or life-support machines. I believe in relieving pain and distress in the terminally ill by the use of drugs which allow the patient to die in comfort but may, stress may, not will, as a secondary effect, hasten death. All of these measures are allowed by the model legislation the South Australian Parliament had the wisdom to pass. I refer to the *Consent to Medical Treatment and Palliative Care Act 1995*.

By prescribing drugs which may hasten death am I therefore practising passive euthanasia so called, as some would suggest? I strongly deny this as I see a clear distinction based on intention to kill. The law of our land considers intention of prime importance eg. the case of a motorist who unintentionally runs down and kills a pedestrian is not murder, whereas a motorist who intentionally runs down and kills a policeman attempting to arrest, is murder.

By withdrawing futile invasive treatment to a dying patient or prescribing drugs which may hasten death I am allowing nature to take its course. I am not intentionally killing the patient. I think the statement on this point made by the House of Lords Select Committee on Euthanasia: I quote "We consider that the law should not make a distinction between mercy killing and other murder. To

distinguish between murder and mercy killing would be to cross the line which prohibits any intentional killing, a line which we think is essential to preserve.”

FALLABILITY IN PROGNOSIS

In my early years as a practising surgeon I was inclined to be dogmatic on matters of prognosis in cancer and head injury patients, but with experience I began to realise just how wrong I could be and became much more cautious. However 10 years ago I must have forgotten my self-imposed caution as this case will illustrate: last Christmas I had a greeting card from an anonymous patient. He said that ten years ago I had operated on him for cancer. After the operation I had told him that the cancer had spread beyond the scope of my surgery and that current surgical knowledge then would give him a 1% chance of being alive in ten years' time. On the Christmas card he went on to say that not only was he alive ten years down the track but also very fit and well and had a recent trip overseas. He signed himself Mr 1%. Such a person could well request euthanasia under such legislation fulfilling the criteria of life being intolerable with a wide spread cancer with virtually no hope of cure.

A further example of prognostic error is illustrated by a patient with whom I was closely involved at the Royal Adelaide Hospital. He was a 17 year old boy with a severe head injury from a road crash. After several months of supportive treatment in which he did not regain consciousness his parents were told by the neurosurgeon that he was unlikely to ever regain consciousness but if he did he would be a 'vegetable'. That boy is now fully recovered, holds down a full time job and to meet him, he appears to have no mental deficit. "One swallow does not make a summer" but I could quote other similar cases from my own practice.

DEPRESSION

Correlation between the desire for death and clinical depression has been documented by a number of authors¹²³ indicating that depression may interfere with judgement, distorting perceptions of reality and the ability to think clearly (although the person may often appear rational). Four of the seven cases described

in the Lancet article entitled “Seven deaths in Darwin: case studies under the ROTI Act in the Northern Territory”⁴ had symptoms of depression.

Clinical depression is very difficult to diagnose. What chance have two ordinary medical practitioners of ascertaining that the person requesting euthanasia was not suffering from clinical depression if only 6% of Oregon Psychiatrists were very confident that in a single evaluation they could adequately assess whether a psychiatric disorder was impairing the judgement of a patient requesting suicide.⁵

MODERN PALLIATIVE CARE RELIEVES THE DISTRESS OF THE VAST MAJORITY OF THE TERMINALLY ILL

There has been a vast improvement in the care of the dying patient during my years of practice. Palliative care has been taught in our Medical Schools only in recent years. In former days unrelieved vomiting was common, pain relief frequently inadequate and the so-called “death rattle” (due to pooling of secretions in the throat and wind pipe) made a lasting impression of horror on the relatives surrounding the death bed of their loved one. I suspect that calls for legalised euthanasia from sincere people have often been triggered by the death of a loved one in these circumstances.

The widespread availability of Palliative Care should be a priority.

To quote a case from my recent experience; I had operated on Mr X age 70 for cancer of the large bowel: twelve months later he developed a recurrence of the cancer partially blocking his small intestine. The second operation revealed widespread cancerous deposits on various parts of his remaining bowel, which could not be removed. Subsequently he developed recurrent bouts of bowel obstruction requiring admission to hospital on a number of occasions for relief of pain and vomiting. Finally he said to me “can’t you end it all Doc?” He had previously told me that his greatest wish was to die at home. I told him I thought I could make him comfortable and allow him to die in peace in the home he had built and loved.

I carried out a minor procedure under local anaesthetic to place a tube in his stomach to siphon off the contents as necessary thus preventing the vomiting but allowing him to take fluids and soft foods by mouth and sent him home with a morphia pump for pain relief. His wife was instructed in the care of the stomach tube and the District Nurse visited when needed. Once his symptoms had been relieved Mr X was a different person. No longer did he want to “end it all”. I visited

him on a number of occasions in his home where he died peacefully and free of pain and vomiting. Mr X is not an isolated case.

Palliative care is improving all the time. It is significant, I suggest, that pleas for euthanasia have been most strident in the Netherlands and the Northern Territory where palliative care facilities are known to have been poor.

VULNERABILITY OF THE ELDERLY

I quote from the 'Advertiser' Thursday August 21st 1997. Under a heading "Abuse of elders a big problem" special writer Nadine Williams wrote and I quote "abuse of the elderly could be as prevalent as child abuse but it remained a hidden problem in society," a Canadian Gerontologist, said in Adelaide. "About 1 in 25 older people in Canada suffered some form of abuse," Toronto based educator, Dr Elizabeth Podnieks told the Sixteenth World Congress of Gerontology in Adelaide. "The tragedy was that older people who were abused financially, physically and emotionally by their adult children blamed themselves. There is physical, emotional, financial abuse and neglect but in most countries financial abuse is the more prevalent form."

If euthanasia or assisted suicide is allowed, there will inevitably be pressure, real or imagined, on the so called "hopelessly ill" to request euthanasia so as not to be a burden on their family. This risk was noted by Chief Justice of the USA Supreme Court, Rehnquist when the Court overturned the 9th Circuit Court of Appeal judgement allowing voluntary euthanasia. He said "We have recognised however the real risk of subtle coercion and undue influence in the end-of-life situations".

Lord Walton (a Law Lord) stated in the report of the House of Lords Select Committee "There would be certain people who for personal or possibly unscrupulous reasons might stretch the legal limits beyond breaking point". It is Parliament's duty to protect the weak and the vulnerable of our community.

WITH LEGAL EUTHANASIA PALLIATIVE CARE SERVICES WILL DECLINE

If the lives of the “hopelessly ill” are allowed to be legally terminated, I believe the incentive to continually improve palliative measures will inevitably wane.

THE TRUST IMPLICIT IN THE DOCTOR/PATIENT RELATIONSHIP WILL BE UNDERMINED.

The vast majority of us would want, when it comes to dying, for our doctor to withdraw life sustaining measures in treating^us if the effect of doing so would merely be prolonging life in a moribund state or in a persistent vegetative state. This is exactly what the present law as embodied in the *Consent to Medical Treatment and Palliative Care Act 1995* allows in South Australia. This has been widely publicised in brochures sent to all doctors and available in their waiting rooms. That is the basis of the present trust we have in our doctor to ensure we have a comfortable death. In a climate of legalised euthanasia many may fear that their life will be terminated unnecessarily to suit the doctor’s convenience. In every walk of life there are unscrupulous people and the medical profession is not immune.

CONCLUSION

We have an Act in this state of South Australia which is compassionate and covers the terminal care of patients so that 95% of those receiving Palliative care may die in comfort. Admittedly there is a small minority who cannot be completely relieved. I am extremely sympathetic to their plight but the common good must outweigh our feelings of sympathy for this very small group.

I submit that it is unwise to supplant the existing laws such as the South Australian 1995 Act with an Act open to the type of abuse I have mentioned.

Five bodies who have looked at voluntary euthanasia have found that it is impossible to frame within an Act adequate safeguards to protect the vulnerable in society.

- The report of the Select Committee of the British House of Lords (Jan 1994) *unanimous*
- The United States Supreme Court's unanimous judgement in the case of Washington et al. V. Glucksberg (1997).
- The report of the New York State Task Force (May 1994) *unanimous*
- The report of the Community Development Committee of the Parliament of Tasmania (1998) *unanimous*
- The Health Committee of the Scottish Parliament (2015)

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¹ Hughes J, Lee D. Depression among cancer patients admitted for hospice care. In: Greer S Thomas C, Editors: Psychosocial oncology Oxford Pergamon, 1987: 193-196

² Haig R Management of depression in patients with advanced cancer. Med J Aust 1992: 156: 499-503

³ Chochinov HM, Wilson KG, Ennis M et al. Desire for death in the terminally ill. Am J Psychiatry 1995: 152:11885-1191.

⁴ Kissane, Street and Nitschke. Case studies under the Rights of the Terminally Ill Act Northern Territory Australia Lancet Oct 1998 v 352 pp 1097-1102.

⁵ Gabzubu, K et al Attitudes of Oregon Psychiatrists towards Physician Assisted Suicide. American Journal of Psychiatry Nov 1996 pp 1469-1475