To whom it may concern:

I am writing from the perspective of a physician in training against the cause of legalising euthanasia in the state of Victoria. Euthanasia, by definition is the wilful killing of an innocent human to ameliorate suffering. It suggests by virtue of its definition that there is limit in suffering where the termination of human life is justified. My arguments illustrate that the 'burden' of illness is the very driver for this proposal in this state and indeed part of the developed world. In doing so I wish to demonstrate that the most vulnerable are open to abuse and only thoughtful and appropriate palliative care can address the concerns that the proponents of euthanasia seek to address.

The ways in which end of life issues have been addressed by the medical profession during the last century have progressed in positive ways. From the development of intensive care medicine and effective anti-microbial and now anti-cancer agents, illness once thought to be life limiting in many circumstances are no longer. This, among other factors, has since challenged hospital residents, nursing staff, registrars and consultants to question the validity of life saving interventions in particular cases. Age and presence of life limiting co-morbidities are taken into consideration, and in some cases, a palliative approach is most appropriate.

Palliative care is the specialty of medicine that attempts to ameliorate suffering in patients where no other medical intervention can reverse inevitable death. The palliative care physicians that are involved in my training constantly reiterate the importance of a good death and importantly, the consideration of dying as a diagnosis. The importance of palliative care as a growing medical specialty parallels the need to face our own limitations as doctors.

The introduction of euthanasia in this decision making process is unlikely to provide any benefits to already well-established palliative care planning. It is counter-intuitive. Death is the inevitable, predictable part of the disease process. Palliative care physicians appreciate the physical and psychic pain that is associated with these processes and address it with careful consideration and respect.

Suffering is the cornerstone of the argument. It is important to note that the aged and chronically ill are not a burden, only their suffering is. It is easier to make the problem go away by introducing euthanasia. It has the allure of resolving not only individual suffering but has the added benefit of controlling it absolutely. This is made absolute in actively terminating somebody's life before problem begins. Given the argument that pain and suffering can be addressed during the life of the patient, active termination of life does not add to this repertoire of care, and does not improve quality of life but only removes the 'burden' of the suffering individual.

Furthermore, we cannot be sure that all issues of pain and suffering have been addressed before the life of a patient ends, regardless of whether we actively intervene in terminating it or not. In the situation where patients willingly request euthanasia outside psychological distress, while empathic to their ideas about the termination of their own life, it is our directive as doctors to foster benevolence towards human life and seek to preserve it.

[1] Cook, Michael, 2014 "Belgian intensive care doctors back involuntary euthanasia", available online via Bioedge.com
[2] Anderson, Ryan, 2015 "Always Care, Never Kill: How Physician-Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality", available online via www.heritage.org

There is significant concern about the eventual introduction of involuntary euthanasia. Evidence out of Belgium describes involuntary euthanasia being considered without due consideration of family, despite currently being illegal[1]. While only voluntary euthanasia is being sought now, involuntary euthanasia is only an argument away. As University of Cambridge professor of law and ethics John Keown stated previously, "Once a doctor is prepared to make such a judgment in the case of [a] patient capable of requesting death, the judgment can, logically, equally be made in the case of a patient incapable of requesting death"[2]. Medical decisions for the best interests for a patient are ultimately given to the patient to make after sound discussion and consideration. If euthanasia becomes standard medical practice, the same applies. In the case where a decision cannot be made by a patient, it is given to a next of kin guided by a doctor. Voluntary euthanasia becomes involuntary euthanasia in the same whim as deciding a Not-For-Resuscitation order, which does not carry the same ethical implications euthanasia does. The potential for abuse involuntary euthanasia is both obvious and frightening.

Even if euthanasia is restricted to individuals of sound mind only to safeguard potential abuse, while intending to provide autonomy, the opposite is true. The desire to die prior to suffering from a life limiting illness even with the best attempts of palliative care to ameliorate suffering only highlights a misguided notion that suffering is burdensome to others as aforementioned. In facilitating a patient's wishes in this way only reiterates this and in doing so restricts their freedom to end life naturally with the best care possible. While their autonomy seems wider by introducing this option, the decision of an individual and their families to enact on this will only be influenced by the societal belief on the burdensome state in which this patient will eventually suffer.

Any safeguards to prevent involuntary euthanasia from occurring will eventually erode away. The ideals in which the safeguards are in place are in direct contradiction to the primary attitude that surrounds the primary appeal of euthanasia; the removal of the burden of suffering. Any society that accepts that suffering people are burdensome despite access to proper palliative care will only cause great harm to the most vulnerable in society.

The question of societal benefit from euthanasia is an ethically dubious one. The removal of the burden of suffering by removing the sufferer will improve public health spending, however, at the cost of discriminating against the most vulnerable. The most vulnerable in our community need to be protected from heavy handed policy decisions such as those that would legislate for euthanasia. This is simply a violation of human rights.

The introduction of euthanasia in the state of Victoria will not enhance patient care; only access to quality palliative care will do so. Voluntary euthanasia is therefore unnecessary and ethically dubious. Furthermore, generations to come will eventually see the introduction of involuntary euthanasia - an even greater ethical concern. The provision of and access to high quality palliative care is the proper response to the needs of the sick and the dying in our community, not the consideration of euthanasia.

[1] Cook, Michael, 2014 "Belgian intensive care doctors back involuntary euthanasia", available online via Bioedge.com
[2] Anderson, Ryan, 2015 "Always Care, Never Kill: How Physician-Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality", available online via www.heritage.org

Kind regards,

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