SUBMISSION CONTENT:

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I am writing this submission as a medical professional who totally rejects all arguments for euthanasia or medically assisted suicide, & who believes that palliative care is, by far, the best end of life choice that can be made. However, I also accept that the care of patients at the end of life by the medical profession as a whole has frequently not served our patients as well as it could have; ie it has not moved heaven & earth to relieve their suffering.

It is because of the sometimes poor performance of the profession that the vast majority of the population gives a positive response to the question 'If a hopelessly ill patient, experiencing unrelievably suffering, with absolutely no chance of recovering, asks for a lethal dose, should a doctor be allowed to provide a lethal dose?' The phrasing of the question has created its own answer; my thesis is that the same relief of suffering is available from a palliative care team & that the message that a lethal dose of medicine given by a doctor is the only way to relieve suffering is a false one.

The achievements of well-funded modern multidisciplinary specialist palliative care are quite remarkable. Statements that it simply isn’t possible for every terminally ill patient to die without pain or intolerable suffering are a reflection of substandard or poorly accessible specialist palliative care. The resolution of these deficiencies requires financial & staff resources; it does not require euthanasia legislation.

When I hear stories of loved ones dying in great distress, I know that the patient has not had all that modern multidisciplinary specialist palliative care can offer. Modern anesthetics can allow the most severe surgery to be performed without a person giving any sign of distress. How is it possible to imagine that palliative sedation, which is essentially anesthetia, cannot relieve intolerable suffering?

Palliative sedation has probably been underused because the patient is not receiving the benefit of specialist palliative care expertise, but also seems to be rejected by many people on quite flimsy grounds: palliative sedation is said to prevent the family saying goodbye; because it is so gradual, palliative sedation is ‘dying
by inches’ (compared with euthanasia which is ‘going out with a bang’). Of course, all of this is immaterial to the most important person involved, viz the patient; a person sedated to the level of unawareness is no longer concerned by the passage of time.

It is said that many patients who are given the means & knowledge to choose the timing of their own death are helped because it relieves their fear & anxiety about unrelieved pain or other suffering. The very real psychological relief from being able to choose the timing of one's death to avoid intolerable suffering can equally be produced by the promise that, should such suffering arise, it will be dealt with by all measures available, up to and including sedation. It seems evident that too many patients are cruelly denied this level of care in their last days by a lack of access to specialist palliative care services; the solution to this problem is better access to specialist palliative care services, not creating access to euthanasia services.

Proponents of euthanasia are prone to say that palliative sedation is just ‘slow stream euthanasia’ & that the drugs used in palliative sedation hasten death just as drugs do in euthanasia. The intentional use of a lethal dose of medication is, of course, completely different from the use of small dose of a medication, even if it could, theoretically, hasten death. In fact, the relief of intolerable suffering in patients with terminal illness has been studied & shown to not shorten their lives compared with patients also in the terminal stage of their life but not receiving such drugs. Patients in the last period of their life who are given small doses of strong drugs to relieve their suffering, to the point of causing sedation if needed, die at the same time they would have otherwise died; they do not die of dehydration nor of starvation but they certainly die more comfortably than they otherwise would.

If there are concerns that patient suffering at the end of life is not being relieved, the answer is surely in better funding & use of what is already available, rather than just killing people.

I would commend the textbook ‘Palliative Medicine’ by T. Declan Walsh et al, 2008, & its chapters on ‘The Desire for Death’ (part 1, section B) & ‘Euthanasia & Physician-Assisted Suicide’ (part 1, section C).

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File1:

File2:

File3: