DOCTORS OPPOSED TO EUTHANASIA

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Authors
- DOE are a voluntary group of medical practitioners, of all faiths and none, who oppose legislation of euthanasia and assisted suicide in any form.
- We wish to address the inquiry as it touches on the issue of euthanasia and assisted suicide.
- Additionally, having a strong interest in the broader issue of care at the end of life, we also comment on better ways to address terminal care.

EXECUTIVE SUMMARY
- End of life care can certainly be improved in Australia substantially. Both the community and the medical profession need better education in Palliative Care practices, to improve awareness of current end-of-life treatment and planning options.
- However, it would be a serious mistake for the community to legalise euthanasia, as it would irreversibly and deleteriously change our society's approach to ageing, dying, suicide and disability. The consequences of legalisation of euthanasia/assisted suicide extend beyond any individuals concerned, because a law change affects the whole community.
- Current State and Common Law protections adequately protect doctors when patients are treated Palliatively, when the intent is not to kill the patient. Therefore law reform in this matter is not needed, rather, better education of the medical profession to counter any uncertainties.

We oppose euthanasia/assisted suicide in general for seven main reasons
1) The prohibition of intentional killing is a bedrock of both the law and medical ethics.
2) The ‘slippery slope’ is inevitable, with incremental expansion over time far beyond the initial ‘hard cases’.
3) Euthanasia will cloud suicide prevention messages
4) Doctors do not want this power, or think they need this power
5) Community support for euthanasia is softer than it seems.
6) Euthanasia will increase the risk of elder abuse
7) Euthanasia ‘controls’ are routinely flouted

A Better way
Most of our membership are involved in care of the dying, including many Palliative Care practitioners. We do not oppose – indeed we actively promote – ‘dying with dignity’. This is better facilitated by:
- active teaching of palliative care skills to all general medical and nursing practitioners, because we perceive that a general lack of such skills is behind some calls for assisted suicide.
- further development of Advanced Care Directives, and encouragement of patients to discuss their preferences with family and treating doctors.
- attention to the needs of family members in terminal care, because we perceive neglect of family distress is a factor in calls for assisted suicide.
BODY OF SUBMISSION

1. We oppose euthanasia/assisted suicide for seven main reasons.

1.1) The prohibition of intentional killing is a bedrock of both the law and medical ethics.
The principle that no human is competent to direct their own death, or the death of another, underpins our society. The British House of Lords called the prohibition of intention killing 'the cornerstone of law and of social relationships'. Euthanasia legislation directly assaults this cornerstone. Cornerstones are relatively simple to remove, but difficult to replace. In most ancient civilizations there were no laws prohibiting euthanasia, infanticide, or capital punishment, but because we have recognized this principle we have outlawed all three. Euthanasia legislation is marketed as progressive politics, but it is, in reality, a profoundly backwards step.

1.2) The ‘slippery slope’ is inevitable
There are only two logically consistent euthanasia positions; prohibition, or extension to all patients (or patient proxies) who request it. If our society accepts the basic principle, that suffering in some cases sanctions medical killing, then extension by degrees cannot be rationally opposed. It will not be logical to deny euthanasia to any ‘reasonable’ person who judges death more desirable than life, as suffering is unquantifiable and inherently subjective.

Once euthanasia is permitted in principle, it is illogical - and ‘inhumane’ - to limit it to those whose suffering is of short duration. If euthanasia is a humane and reasonable way to reduce a short period of suffering, how much more humane is it to assist suicide when unrelieved suffering might persist for decades? From one perspective life itself is a terminal illness. In the Netherlands, after 30 years of Euthanasia, one in five doctors could conceive killing an otherwise well patients who is tired of life, and on in fifty has actually done so. The feared consequences of this legislation are its precise inherent consequences.

DOE respects Philip Nitschke for having the courage of his convictions, and the moral clarity to follow his beliefs through to their logical conclusion - he has previously stated that euthanasia should be available to any mentally competent adult who requests it. The recent case of facilitated suicide for depression (which led to his registration suspension) embodied his position. It is all perfectly reasonable and logical if one accepts the premise, that to eliminate suffering we are permitted to kill the sufferer. But we of course reject this premise, and we urge you to reject it also.

Furthermore, if death to eliminate suffering can be seen as a good, then why restrict it to people who can request it? Why let intellectually disabled neonates and their parents suffer? Why leave the demented patient in the nursing home confused and incontinent? This is not scaremongering – it has been validated by the experience of other countries. While it is deeply regrettable that the Netherlands and Belgium have allowed euthanasia, it has at least clarified that the slippery slope argument is real. Dutch euthanasia has progressed from the non-prosecution of Dr Postma for the killing of her wheelchair-bound, deaf, 78 year-old mother, to euthanasia for dementia, euthanasia for depression and anorexia nervosa, non-voluntary euthanasia (i.e. nurses killing patients deliberately without their request), euthanasia for younger patients with non-lethal physical disability, euthanasia of infants, and euthanasia of the elderly are ‘weary of life’. It has led to mobile euthanasia teams and euthanasia for the procurement of ‘good quality’ organs for transplant.
1.3) Euthanasia will cloud suicide prevention messages
Our current mental health act (in a de facto fashion) defines suicidality as mental illness, because depression and ‘rational’ suicidality cannot easily be separated. However, once the underlying logic of euthanasia is accepted, suicide becomes just another reasonable choice. By what logic could suicide for physical suffering be facilitated, but suicide for mental suffering continue to be prevented by psychiatric incarceration? Legislation for assisted suicide is incompatible with mental health programs to prevent suicide, and treat depressive illness.

1.4) Most doctors do not want this power, or think they need this power
It is noteworthy that support for euthanasia declines in inverse proportion to the person’s exposure to dying patients. This is of course the opposite of what would be expected if euthanasia was truly desirable or necessary. While community support seems to be strong, nurses’ support is lower, doctors’ lower again, and Palliative Care doctors’ lowest of all. If euthanasia were so wonderful, those most likely to perform it would be clamouring for it, but the opposite is true. As well as many Medical organisations worldwide, including the World Medical Association and Australian Medical Association, it is noteworthy that both The Australia and New Zealand Society of Palliative Medicine (ANZSPM) and Palliative Care Australia (PCA) all oppose it. This opposition has been repeatedly confirmed despite well-organised, well-funded euthanasia lobbying.

1.5) Community support for euthanasia is softer than it seems.
The recent Massachusetts referendum on euthanasia should give legislators pause. Community support for the legislation seemed inevitable when the Bill was proposed, but over the course of the debate, as people considered it more deeply, the momentum shifted, from 68-20 pro, to 51-49 against.

Once more, if a moral issue demands change, the more closely it is considered, the stronger the case for change will seem. For euthanasia, the more closely it is considered, the more likely it is to be rejected. Many of our members have had patients who initially mentioned a desire for euthanasia, only to change their wishes once care is discussed and delivered. Of course if euthanasia is legalised, these patients will no longer have the luxury of changing their minds.

1.6) Euthanasia will increase the risk of elder abuse
As much as we like to believe otherwise, we do not make our decisions as isolated autonomous individuals, but within a web of influences and relationships. Again, to quote the 1994 House of Lords report, ‘Individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions. The issue of euthanasia is one in which the interests of the individual cannot be separated from those of society as a whole.’

If assisted suicide or euthanasia legislation is enacted, it is highly likely, over time, that elderly patients will feel an increasing obligation to take their own lives. Fear of being a burden is a common reason for euthanasia. Medical expenditure in the final year of life swallows a huge proportion of the health budget, and the final stages of life demand much time and energy from family supports. It will be viewed as selfish, to spend so much of society's precious money, to waste the childrens' inheritance, to take up so much time, to be the cause of such emotional distress, when a simple, cheap and painless solution is so readily at hand. Elderly patients will not only be vulnerable to this diffuse societal pressure, but may sign euthanasia consent after subtle (non-convictable) coercion from family members or carers. Euthanasia legislation is incompatible with concerns about elder abuse.
1.7) Euthanasia 'controls' are routinely flouted

It is evident, where euthanasia is legally practised, that so-called safeguards, controls and reporting mechanisms have been largely ineffective. In a recent Belgian survey only 53% of euthanasia deaths were reported and 32% of euthanasia deaths were found to have occurred without explicit request or consent. Yet, despite a legislative requirement, none of these cases have ever been referred by the Euthanasia Evaluation Commission to the relevant authorities for investigation, let alone been prosecuted.

The Netherlands does slightly better - in 2010, 77% of cases were reported and (only) 330 persons died in that year without explicit request or consent. But, yet again, no prosecutions have occurred. Harold Shipman was a UK doctor who killed patients in nursing homes for pleasure. In Belgium and the Netherlands, he would have had a convenient cloak for his evil actions and may never have been discovered. Our legal system should not facilitate the Harold Shipmans of this world.

As a Dutch euthanasia advocate (Prof Theo Boer) who has recently changed his mind urged "Don't go there. Once the genie is out of the bottle, it is not likely to ever go back in again.” Belgium and the Netherlands are disasters to be avoided, not examples to be emulated.

2) Doctors to do not need further Legislative protection to enable them to provide proper Palliative treatment.

It has recently been proposed by Victorian authors that the problem of Euthanasia can be solved by a ‘minimalist solution’. The authors obscure the matter at hand by claiming that their proposal simultaneously protects doctors from prosecution when a patient inadvertently dies in the setting of Palliative Care.

'We propose that legislation be enacted to amend relevant Commonwealth and state criminal legislation to provide a defence to a charge of homicide or manslaughter when a doctor has prescribed or administered a drug that has hastened or caused the death of a patient with a terminal disease. This defence would be allowed if the doctor: (a) reasonably believed that it was necessary to prescribe or administer the drug to relieve the pain or suffering of the patient; or (b) prescribed or administered the drug with the intention of relieving such pain or suffering.'

We would urge the committee to reject this proposal, if presented for consideration. The difficult moral dilemma of Euthanasia is not to be solved by sleight of hand, in which the vital and necessary distinction between intentional and non-intentional killing is blurred.

Common law, encapsulated by the South Australian Palliative Care Act, reflects the current legal position regarding non-euthanasia end-of-life care. Whether protected by common law or by legislative law, doctors in Australia are protected from liability when treating the terminally ill, even if treatment incidentally (i.e. non-intentionally) hastens death.

There has not been a single instance in Australia of prosecution for what is universally accepted as good and morally acceptable Palliative Care. If there is a problem to be solved, it is to be solved by educating doctors involved in the care of dying patients, not by changing the law as suggested.
3. A Better Way
Most of our membership are involved in care of the dying, including many Palliative Care practitioners. We do not oppose – indeed we actively promote – ‘dying with dignity’, and have had significant involvement in the South Australian Advanced Care Directives Bill.

We believe that End-of-life care can be enhanced by the following initiatives.

a) active teaching of palliative care skills to all general medical and nursing practitioners, because we perceive that a general lack of such skills is behind some calls for assisted suicide.
   - the average Medical Student receives minimal training in Palliative Care
   - most doctors and nurses (let alone the general community) are unaware of the extent to which ‘refractory’ symptoms can be managed with specialty input
   - there persists a degree of confusion in the medical community around what does and does not constitute euthanasia

b) further development of Advanced Care Directives, and encouragement of patients to discuss their preferences re offered treatment with family and treating doctors.
   - DOE strongly endorses patient autonomy, in refusing or agreeing to the provision or non-provision of medical care
   - a degree of confusion exists in the community regarding the refusal of medical care and euthanasia
   - this confusion will be lessened by the normalization of discussion around declining treatment at the end of life
   - ACDs allow treatment at the end of life to be patient-centered
   - ACDs empower both patients and health professionals

c) attention to the needs of family members in terminal care, because we perceive neglect of family distress is a factor in calls for assisted suicide.
   - End-of-life Care must involve and support the carers and family of a dying patient.
   - Attention to the dying patient’s carers’ perceptions of the patients symptoms and symptoms are vital in achieving what is perceived to be a ‘good death.

As a final note, we would urge the committee to read in full the recent Case report on Palliative Care in the New England Journal of Medicine ‘A 44-year-old woman with intractable pain due to metastatic lung cancer’. Not only does this patient’s case exemplify gold standard treatment of the dying patient, it also discusses sensibly and dispassionately the ethical distinctions between Euthanasia and Palliative sedation, and how this latter option is both effective and universally morally unproblematic for patients with refractory symptoms at the end of life. In doing so it also deftly deals with the topic of ‘double effect’.

Yours Sincerely,

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