Submission: Parliament of Victoria

Inquiry into End of Life Choices

To:

Standing Committee on Legal and Social Issues
Parliament of Victoria
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Introduction

In the wake of requests to legalise euthanasia, highlighted by tragic personal accounts of the suffering associated with terminal illness, it is natural and proper that governments work to ensure adequate relief for those with such conditions. The ideal of safely legalising euthanasia in any of its forms is not new; however, nor is it the answer to this complex issue. The evidence has unequivocally demonstrated that despite the best efforts of legislators, attempts to safeguard euthanasia have consistently failed.

This submission sets out why euthanasia is a dangerous public policy and why the safeguards in this bill will not work in practice. It highlights what the evidence shows: the real solution lies in providing adequate palliative care.

Why Euthanasia is a dangerous public policy

Creating danger for masses of vulnerable people for the sake of a few is gravely flawed public policy. In a report produced by the New York State Task Force on Life and the Law in 1994, even those members who did not see euthanasia as unethical or incompatible with medical practice concluded that ‘legalising assisted suicide would be unwise and dangerous public policy.’ The Task Force noted that the number of cases when assisted suicide or euthanasia is medically and ethically appropriate is extremely rare; that the benefits incurred for this small number of patients could not justify a major shift in public policy or the serious risks that legalising the practice would entail; and the legal prohibition of such practices serves important purposes and is a highly symbolic function.¹

Proper examination of the available evidence demonstrates that legislative safeguards have inevitably failed in practice.

The term ‘terminal’

The lack of consensus on the medical definition of ‘terminal’ or ‘terminal illness’ means that whether a person’s condition is in fact terminal is subjective. The problem is best highlighted by David Kissane in an examination of euthanasia performed by Dr Philip Nitschke in the Northern Territory in 1996-1997 under the Rights of the Terminally Ill Act 1995:

The purpose of the Regulations was to protect the broader community and in particular vulnerable patients, while permitting a healthy and rational individual to choose euthanasia for him or herself. A key intent of the legislation was however that the patient did suffer from a terminal illness. The above cases illustrated how problems developed with this assessment of prognosis, best exemplified when different specialists gave varied estimates of Janet Mills’ potential length of life. There was no capacity within the Regulations to deal with such a difference of opinion. Moreover, when an orthopaedic surgeon came forward following Mill’s public appeal for a certifying specialist, and he did not have expert knowledge of mycosis fungoides, a rare tumour involving both the skin and lymphatic systems but not the bones, this was ignored by relevant authorities. Such breaches of the Regulations were permitted by a legal system wanting to facilitate the legislation, thus removing the very safety features that had been designed to protect the vulnerable.²
Even if a clear definition of ‘terminal illness’ existed, it remains unclear as to why legalised voluntary euthanasia and physician-assisted suicide should be limited to terminally ill patients. Similar levels of distress may be experienced by people in a variety of conditions, including those with an incurable progressing degenerative disease with many years of unendurable existence ahead.

**Second opinions**

Under the Northern Territory’s Rights of the Terminally Ill Act 1995, the doctors that acted as the second medical practitioner were frequently not appropriately qualified to act in that position. David Kissane explains:

*The second medical practitioner was to be a specialist with expertise in the disease. One might have expected this to be a medical or radiation oncologist for patients with cancer, but instead we found that surgeons filled this role. Clearly they are involved in the diagnosis and initial management of cancer, but in our society, ongoing care is usually then transferred to a cancer specialist. There was one oncologist working in Darwin by the time the Act became law, but Nitschke found that only surgeons were willing within this community to certify that the patient was terminally ill, a curious state of affairs.*

**Mental Illness**

Legislation to legalise voluntary euthanasia represents a serious danger to those suffering from mental illness in the course of their terminal illness. So-called ‘protections’ within the Bill to ensure that the applicant is of sound mind and that the applicant’s request for euthanasia is not wholly or substantially referable to, or a symptom of, a state of clinical depression will not protect terminally ill patients with depression or other mental illnesses from being euthanised.

**Familial expectations**

Rather than serve as a protective factor, consideration of a person’s family may well push that individual to request euthanasia. Experience in palliative care indicates that in addition to the patient’s own emotional needs, it is the family and friends more than anyone else, who will influence the mood and mindset of the patient, and may unwittingly reinforce negative thoughts and attitudes. It is apparent in the experience of assisted suicide that the family and other caregivers are under severe emotional strain, and the option of assisted suicide is a ready relief for their emotional burden, and not simply the patient’s. It is foreseeable that a patient would be aware of the emotional burden placed on their loved ones, and would hope to alleviate this. Therefore legislative stipulation is unlikely to protect an individual from choosing euthanasia as a result of actual or perceived pressure relating to their family.

**Duty to Die**

To legalise euthanasia on the basis of the patient’s free and informed decision to end their life is dangerous since it is difficult to determine whether a patient’s request is in fact ‘free and voluntary’. The mere legalising of euthanasia places an unacceptable pressure on vulnerable people in our society to comply with a ‘duty to die’. Tony Burke, Executive Director of Euthanasia NO has described this pressure in the following terms:
‘When people are considering whether or not they should be able to have a treatment or discontinue a treatment, the question is usually, ‘Is the treatment a burden?’ With euthanasia, we keep getting asked, ‘Is the person a burden?’ So for a vulnerable patient, who never would have requested euthanasia, the mere existence of the act – the mere existence of this as an option that has to be presented – is, in itself, a pressure.\textsuperscript{8}

Even advocates of so-called ‘rational suicide’ have themselves admitted the clear and present danger of manipulated suicide. Margaret Pabst-Battin, a ‘suicidologist,’ has acknowledged the strong possibility that relatives, or others, could subtly push an individual into ‘choosing’ death.\textsuperscript{9}

Of perhaps greater concern in relation to this legislation is the notion that medical practitioners themselves may well influence a person’s decision to be euthanised. Professor Alan Roger, Monash University, recognised that the medical profession is not omniscient, stating:

\begin{quote}

‘... my fellow practitioners and I are mere humans. We make mistakes – in diagnosis, in treatment and, notoriously, in prognosis. Some of us are also unethical. No Act can be perfect and hence prevent all mistakes or abuse.’
\end{quote}

Where euthanasia becomes normalised as part of medical practice, a medical practitioner may become conditioned by his or her involvement in euthanasia to project on to patients with certain conditions a strong expectation that euthanasia is the appropriate “treatment” for them. In such cases, it is unlikely that the medical practitioner, as the source of undue influence, will negate the patient’s request for euthanasia on the basis of their free and voluntary choice being compromised.

**Why palliative care is the better alternative**

Palliative care has always operated on the premise that ‘it neither hastens nor postpones death’ and therefore ‘none of the treatments given, including narcotics, are aimed at harming or killing the patient, but are designed to assist in relieving symptoms.’\textsuperscript{10} This does not mean a flood of treatment leading to negligible quality of life. Indeed, Dr Pieter Admiraal, recognised as one of the pre-eminent leaders of the Dutch euthanasia movement and an experienced anaesthesiologist, has said that pain relief is not a good reason for euthanasia. This is because even the pain of the most difficult cancers can be treated and the patient does not need to be “knocked out” or “doped silly” if proper pain management techniques are used.\textsuperscript{11}

Dr Admiraal states, in relation to cancer patients, that ‘cancer pain’ means real physical pain combined with fear, sorrow, depression and exhaustion. He writes that ‘this kind of “pain” is an alarm signal indicating shortcomings in interhuman contact and misunderstandings of the patient’s situation. One can treat this “pain” with good terminal care based on warm human contact.’\textsuperscript{12} This second form of suffering, relating to ‘existential problems’ that include ‘loss of self-worth, loss of control, fear, guilt, anger, resentment and anxiety at being so disabled’ are said to lead patients to request euthanasia more often than pain does.\textsuperscript{13} Evidence from palliative care specialists has shown that requests for voluntary euthanasia or assistance in suicide are extremely rare when concerted efforts are made to alleviate the physical, spiritual and emotional forms of suffering in terminally ill patients which palliative care addresses.\textsuperscript{14} According to this evidence, requests for euthanasia are usually a call for help rather than a call for euthanasia.\textsuperscript{15}
It is unsurprising then, that patients frequently cease their requests for euthanasia once they have been provided with adequate palliative care. Dr Kathleen Foley, a Neurologist at the Memorial Sloan-Kettering Cancer Center, New York, with clinical expertise in cancer pain and supportive care, has reported that the Center frequently sees patients referred to the Pain Clinic who have considered suicide as an option, or who request physician-assisted suicide because of uncontrolled pain. She states that it is common for such ideation and requests to dissolve with adequate control of pain and other symptoms using combinations of pharmacological, neurosurgical, anaesthetic or psychological methods.\textsuperscript{16}

**Conclusion**

Although the legalisation of euthanasia may be noble in spirit, it is flawed in its essence. Where euthanasia has become legal it has had unintended consequences: vulnerable people have died. These deaths have occurred despite many attempts to safeguard the relevant legislation, such as the process that is stipulated by this very bill. Our very acknowledgement of the existence of elder abuse in our country by definition guarantees adverse outcomes if euthanasia is legalised. Meanwhile legalising what is in effect assisted suicide does nothing to aid our considerable collective efforts in suicide prevention. Mixed messages are bad messages. An academically rigorous evaluation of the research in this area together with the experiences of those few jurisdictions that have opened this dangerous door leads to the conclusion that legalising euthanasia is not an example of responsible public policy; yet there is an effective alternative. There is ample evidence to show that adequate palliative care provides relief for the physical and psychological pain that is experienced by people with terminal illnesses. Palliative care is the more compassionate choice.

\begin{enumerate}
\item Brian P. Johnston, *Death as a Salesman – What’s Wrong With Assisted Suicide* (1998) 17.
\item Ibid 18.
\item *Evidence*, Euthanasia NO, p 219, quoted in Federal Senate Committee Report (1997), paragraph 6.57 at 70.
\item Submission No. 4538, Council of the Australian and New Zealand Society of Palliative Medicine, p 4, referenced in Federal Senate Committee Report (1997), paragraph 6.75 at 74.
\item Dr P. Admiraal, speech before the Biennial Conference of the Right to Die Societies, Maastricht, Holland (1990), referenced in Brian P. Johnston, *Death as a Salesman – What’s Wrong With Assisted Suicide* (1998) 24.
\item *Evidence*, Australian and New Zealand Society for Palliative Medicine, p. 134, referenced in Federal Senate Committee Report (1997), paragraph 6.83 at 75.
\item Submission No. 4518, Professor T. Cramond, p 2 and Submission No. 4462, Professor J. Murtagh, p 1, referenced in Federal Senate Committee Report (1997), paragraph 6.84 at 76. See also Sidney H. Wanzer, et

15 *Submission No. 4512*, Dr R. Chye, p 1, referenced in Federal Senate Committee Report (1997), paragraph 6.84 at 76.