

Euthanasia lives again

Social Issues briefing #102, 03/05/2013.

On Thursday 2nd May 2013, the NSW Greens MLC, Cate Faehrmann, introduced to the NSW Parliament's upper house a [bill to make assisted suicide legal](#) in this State, under certain conditions. It is a private members' bill, which she has given a speech to commend. MLCs will likely debate it again next Thursday 9th May.

The Bill will make it lawful for persons with a terminal illness who are resident in NSW to receive assistance in certain circumstances if they wish to end their life. That is, it will legalise a form of euthanasia in NSW. The NSW Greens previously proposed euthanasia legislation in 2010, which ultimately failed in the Parliament.

Although this Bill proposes various 'safeguards', we don't believe the basics have changed. Euthanasia is not and never will be a 'safe' way to conduct health 'care'. Our arguments and comments on this topic, arising from previous debates, are collected here: www.sie.org.au/about/euthanasia.

If you agree that this Bill, though well-intentioned, is ultimately a bad idea, please make your voice heard. You could draw from any of the material mentioned below, but please try to put it on your own words, as an expression of your own convictions. Cutting and pasting impresses no one in politics. Respectful, heartfelt entreaty does make a difference.

Remember how it works: the Bill must first be passed by the NSW Legislative Council, before it can progress to the Legislative Assembly (the house where you are represented by your NSW local member).

Therefore if you wish to influence the debate, you would first contact Members of the Legislative Council (the NSW Parliament's equivalent of Federal Senators). They are not the same as your local NSW lower-house member (your MLA).

Contact details for all members of the Legislative Council can be obtained via www.parliament.nsw.gov.au. Correspondence can also be mailed via:

*[Name of Member of the Legislative Council],
c/o Parliament of New South Wales,
Macquarie Street,
SYDNEY NSW 2000.*

You are allowed to contact one, some or all of these people.

But we also strongly encourage you to make this issue known to your local NSW MLA, in the event that the Bill progresses to the lower house.

Over the page, you'll find Dr Megan Best's response to euthanasia in general and to this Bill in particular. Dr Best, a member of the Social Issues Executive, outlines why the Bill should be opposed. She is a bioethicist and medical doctor who specialises in palliative care.

- **Andrew Cameron**
for the Social Issues Executive, Diocese of Sydney

Notes on the Rights of the Terminally Ill Bill 2013
from Dr Megan Best

We call on the State Government of NSW to vote against this bill. We believe that a civilized society should not deal with the problem of sick and suffering persons by killing them or allowing them to kill themselves, but by relieving their distress and making the required support available. Furthermore we believe that such a path would lead to vulnerable patients being persuaded to request assisted death when it is not what they really want.

Advances in palliative care make assisted death unnecessary.

- Advances in palliative care have improved the symptom control of patients at the end of life and where expertly used, suffering is minimal. ¹ The World Health Organisation recommends early introduction of palliative care for patients with terminally illness and not as a last resort.²
- Where suffering is due to existential and not physical causes, pastoral or psychological support and not death is the appropriate response.³
- There is a myth that use of pain-relieving medications such as morphine shortens life. This promotes the impression that palliative care already promotes euthanasia. This suggestion is untrue and current research suggests that in fact adequate doses of morphine and other pain-relieving medications increase survival.⁴ Our community would be less concerned about care at the end of life if they knew more about it.
- Furthermore, in those places where euthanasia and physician-assisted suicide are legal, pain is not a common reason for requesting these interventions. Psychosocial concerns such as fear of loneliness and fear of the future are more common.⁵
- Current government initiatives promoting advance care planning (which is common in palliative care settings) can alleviate many fears for the future for chronically or terminally unwell patients.⁶
- While many healthy people in the population may believe that they would like to have access to assisted dying at the end of life⁷, the number of people with advanced illness who request it in Australia is very low, and even lower (less than 1%) once palliative care is introduced.⁸

¹ World Health Organization. (1996). Cancer pain relief (2nd ed.). Geneva: WHO.

² Sepulveda C, Marlin A, Yoshida T, Ullrich A. (2002) Palliative Care: the World Health Organisation's global perspective. *Journal of Pain & Symptom Management*. 24(2): pp.91-96.

³ Roy FDJ, Rapin C-H et al. (1994). Regarding euthanasia. *European Journal of Palliative Care*, 1(1), 1-4.

⁴ Good PD et al. (2005). Effects of opioids and sedatives on survival in an Australian inpatient palliative care population. *Intern Med J*, 35, 512–517.

⁵ Hudson P et al. (2006). Desire for hastened death in patients with advanced disease and the evidence base of clinical guidelines: a systematic review. *Palliative Medicine*, 20, 693-701.

⁶ Respecting Patient Choices. www.respectingpatientchoices.org.au.

⁷ News poll (2009) Voluntary Euthanasia Study. Prepared for Dying with Dignity NSW.

⁸ Glare, P. A. (1995). "The euthanasia controversy. Decision-making in extreme cases." *MJA* 163: 558.

Legislation of assisted dying is dangerous

- Patients with advanced illness are known to change their mind about treatment over time. This means that a patient who may request assisted dying at one stage may change their mind if given more time, thus ending their life prematurely.⁹
- This bill does not specifically guard against patients with clinical depression from requesting assisted dying. Depression is known to be associated with a desire to die, and is a treatable disease. Research shows that sometimes when patients expressed their fears at the end of life it was misinterpreted by healthcare providers as a request for euthanasia when it was really intended to be a cry for help.¹⁰ The incidence of depression in cancer patients may be as high as 45%.¹¹ This is known to be a problem in other jurisdictions despite so-called 'safeguards'.¹²
- Suicide rates in our community are already a cause of concern. Legislation allowing assisted death promote the idea that death is an acceptable way to solve problems in life, increases knowledge of suicide techniques and makes an increased amount of lethal substances available within the community.¹³
- The availability of assisted death as an option for vulnerable patients may be sufficient to cause them to request it even if they do not want it, because they do not want to be a burden on their families.
- In those jurisdictions where euthanasia and physician-assisted suicide are legal, extension of legislation beyond those who do or can consent, who are not terminally ill, or are minors has followed.¹⁴ Although we do accept that some small number of individuals will want to exert their autonomy (the right to choose the timing and manner of their own death), we believe the role of the government is to protect the vulnerable who would be at risk if this bill is passed. This is the conclusion of government-sponsored enquiries in England, Canada, USA and Australia.¹⁵

⁹ Chochinov H et al. (1999). Will to live in the terminally ill. *Lancet*, 354, 816–19.

¹⁰ Hudson, *ibid*.

¹¹ Passik SD, McDonald MV, Dugan Jr WM, Edgerton S, Roth AJ. (1997). Depression in Cancer Patients: Recognition and Treatment. *Medscape Psychiatry & Mental Health eJournal*, 2(3).

¹² Ganzini L, Goy ER, Dobscha SK. (2008). Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey. *BMJ*, 337, a1682.

¹³ *Journal Of Forensic Science* 2011

¹⁴ *Medische Beslissingen Rond Het Levenseinde – Rapport van de Commissie Onderzoek Medische Praktijk insake Euthanasie*. The Hague, The Netherlands: Sdu Uitgeverij, 1991; Sheldon T. (1994). Dutch argue that mental torment justifies euthanasia. *BMJ*;308:431-432; Dutch News.nl. 09-02-2010. Tired of life? Group calls for assisted suicide; Verhagen, E,Sauer PJJ. (2005). The Groningen Protocol — Euthanasia in Severely Ill Newborns. *NEJM* 352(10): 959-962; H Jochemsen Euthanasia in Holland: an ethical critique of the new law; Jochemsen H,Keown J. (1999). Voluntary euthanasia under control? Further empirical evidence from the Netherlands. *Journal of Medical Ethics* 1999;25: 16-2 1; Hendon H, Foley K. Physician-Assisted Suicide in Oregon: A Medical Perspective. *Michigan Law Review*. 2008;106.

¹⁵ U K Select Committee on Medical Ethics, House of Lords. (1994). (Unanimous); New York State Task Force on Life and the Law, *Euthanasia and Assisted Suicide in the Medical Context*, (1994). (Unanimous); Senate of Canada, (1995) *Of Life and Death*; Community Development Committee, Parliament of Tasmania, *The Need for Legislation on Voluntary Euthanasia*, (1998). (Unanimous); Social Development Committee, Parliament of South Australia. *Report of the Inquiry into the Voluntary*

We do not suggest that our current care of the living and dying in our community is perfect. However, rather than the legislation of euthanasia or assisted suicide we call on the government to:

- Improve resources for palliative care so that terminally ill patients in our community have the comfort they need at the end of life to minimize suffering. Patients need access to palliative care, not just awareness that it exists. Currently there are many populations in Australia with inadequate access to palliative care, including the very old, the very young, patients with a non-cancer diagnosis, private patients, nursing home residents, patients in rural and remote settings, and non-English speaking patients.¹⁶
- Government support for the disabled in our community should be improved so that those who require assistance to do the activities of daily living are able to live a dignified and meaningful life.
- Our community needs to be educated regarding the benefits of aging well so that age alone is not seen as a reason to give up on life.

We call on our government to affirm the value of every human life and not give up on our weaker citizens in terms of supporting them in their most vulnerable moments.

My concerns about this legislation

- Part 1(3) 'Terminal illness' is defined as one which will result in the death of the patient. There is no mention of a patient's prognosis in relation to meeting the eligibility criteria. A condition such as diabetes may have a natural history of decades before leading to premature death. Is such a patient eligible for assisted death once diagnosed? Currently any chronic disease, even one which can be managed in such a way as to prolong life, satisfies the conditions of the bill.
- Part 2. 7(1)(d) While patients are required to have severe pain and suffering and informed of options, there is no requirement that they be assessed and the options exhausted before proceeding on the assisted death pathway. Also the primary medical practitioner merely has to have experience of palliative care (2.7(3)) and may not be up to date with what is available.
- 2.7(1)(i)(ii) The secondary medical practitioner does not have to have specialized knowledge of the disease involved, merely experience of it and the amount of experience is not defined. This could mean the secondary medical practitioner is not a medical specialist in the required field and may not be up to date with latest research.
- 2.7 (1)(g)(h) The psychiatry review is to assess decision-making capacity only. Clinical depression is known to influence decision-making regarding desire for death and is a treatable illness. This also should be assessed.
- 2.7 (2) There are no 'medical standards' regarding the killing of patients. Therefore clause Part 7(2) is meaningless.
- In jurisdictions where the only reporting of assisted death is through the doctor involved, it has been impossible to keep track of the exact number of cases occurring.¹⁷ It has also been impossible to study the motivation for requests in a meaningful way. If the use of such legislation is to be intended

Euthanasia Bill 1996. (1999).

¹⁶ Palliative Care Australia. (2009). EOL, 1(2).

¹⁷ Smets T, Bilsen J, Cohen J, Rurup ML, Mortier F, Deliens L. (2010). Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported Cases. BMJ 2010;341:c5174.

to improve the lot of dying and suffering patients, reporting should include information supplied directly by the patient involved, i.e. before death.¹⁸

- Also for safety of the community, a record should be kept of prescriptions for lethal substances and when and by whom they are filled. When a patient withdraws consent (2.9) the lethal substance should be obtained from the patient by the doctor and returned to the pharmacy.

- **Dr Megan Best**
for the Social Issues Executive, Diocese of Sydney

Note: This paper is intended to assist discussion and may be corrected or revised in future. Short responses to social.issues@moore.edu.au are very welcome, but the SIE cannot guarantee a reply. To access this occasional free briefing, use RSS at www.sie.org.au; or to receive it by email, ask us at social.issues@moore.edu.au or do it yourself at <http://lists.moore.edu.au/mailman/listinfo/social-issues>.

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¹⁸ Hendon H, Foley K. Physician-Assisted Suicide in Oregon: A Medical Perspective. Michigan Law Review. 2008;106.