



# Archbishop of Sydney

Committee Secretary  
Senate Legal and Constitutional Affairs Committee  
PO Box 6100  
Parliament House  
Canberra ACT 2600  
[legcon.sen@aph.gov.au](mailto:legcon.sen@aph.gov.au)

**Inquiry into the Medical Services  
(Dying with Dignity) Bill 2014  
Submission from the Office of the Archbishop,  
Anglican Church, Diocese of Sydney**

Thank you for the opportunity to make a submission to this inquiry into the exposure draft of the Medical Services (Dying with Dignity) Bill 2014 (“the Bill”), with particular reference to the rights of terminally ill people to seek assistance in ending their lives, and an appropriate framework and safeguards with which to do so. As Archbishop, I write on behalf of Anglicans in the Diocese of Sydney.

I would like to make clear from the outset that I am happy for my submission to be made public. I would also be glad for an opportunity to appear before the Committee to debate this submission and examine the Bill in more detail.

In general, my submission expresses grave concerns about the justice of the Bill. It fails to understand and protect the rights of terminally ill people; and it outlines a practice which, far from being appropriate and safe, would almost certainly open the door to intentional and unintentional abuses with terrible consequences.

My reasons for this view can be summarized under four headings:

First, I do not find persuasive the arguments in favour of a right to request euthanasia or physician-assisted suicide (PAS), and believe that the form in which this right is recognised in the Bill is extremely problematic.

Second, evidence from other jurisdictions clearly demonstrates that euthanasia and PAS cannot be appropriately framed or adequately safeguarded.

Third, the Bill fails to adequately account for the reality of modern palliative care practice.

Fourth, there are significant problems with particular aspects of this Bill.

The Most Rev Dr Glenn N Davies  
Anglican Diocese of Sydney  
St Andrew's House, Sydney Square. PO Box Q190, QVB Post Office NSW 1230  
Telephone: + 61 2 9265 1521. Email: [archbishop@sydney.anglican.asn.au](mailto:archbishop@sydney.anglican.asn.au)

## 1. On the right to “die with dignity”

*I do not find persuasive the arguments in favour of a right to request euthanasia or physician-assisted suicide, and believe that the form in which this right is recognised in the Bill is extremely problematic.*

One of the objects of the Bill is “to recognise the right of a mentally competent adult who is suffering intolerably from a terminal illness to request a medical practitioner to provide medical services that allow the person to end his or her life peacefully, humanely and with dignity” (§3(a)). Recognition of such a right would be an innovation in both Australian and international law. Very few countries have taken such a step, and there are many jurists who regard it as mistaken. It is not at all clear that any person, even someone in terrible suffering, has a *right* to end their life, in the sense of a freedom rightly secured for them by law. It is much less certain that a person has a right to request assistance to do so. Although the wording of the Bill obscures this point, at issue is whether a person may have a right to ask someone to kill them. I strongly believe that this is not a right a person in fact possesses, and that the law should certainly not recognise it as such. I believe that the recognition of such a right cannot but undermine much more secure and positive rights which are central to the right to life. To recognise a right to die in certain circumstances is to turn the right to life into a right to a certain kind of life, which is an extremely dangerous innovation.

Moreover, the form in which this right is recognised in the Bill is extremely problematic. There are two particular problems. First, the use throughout the Bill of the language of “dying with dignity” in place of euthanasia and PAS obscures the most important issues at stake and evades any opportunity for debate. It frames the issue in a highly emotive way and obscures distinctions of enormous moral importance, most significantly between suicide and death at the hands of another. Moral questions are not helped by discussing them in emotionally loaded terms. In this highly sensitive area of moral complexity, there are extremely weighty issues at stake that should not be evaded by emotive rhetoric.

Second, framing the practices of euthanasia and PAS in terms of “Medical Services” avoids facing the reality that this is a major innovation in the very concept of medicine. As Canadian Law Professor Margaret Sommerville has written,

Euthanasia takes both [the profession of medicine and its practitioners] beyond their fundamental roles of caring, healing and curing whenever possible. It involves them, no matter how compassionate their motives, in the infliction of death on those for whom they provide care and treatment. Euthanasia thus places the soul of medicine itself on trial.<sup>1</sup>

The possibility that, as a form of “treatment” a doctor might kill a patient is a change to the very notion of medicine, representing a fundamental departure from the basic principles of the Hippocratic Oath. Given this point, I do not believe that a “Medical Services” Bill is a prudent form in which to introduce the practices of euthanasia and PAS into Australia. Too many issues of grave importance are being evaded.

## 2. The impossibility of adequate safeguards

*Evidence from other jurisdictions clearly demonstrates that euthanasia and physician-assisted suicide cannot be appropriately framed or adequately safeguarded.*

*The Netherlands and Belgium.* In those jurisdictions where euthanasia and PAS have been adopted, evidence clearly shows that seemingly reasonable safeguards are constantly circumvented, and dangerous abuses and expansions inevitably eventuate. Commenting on the

---

<sup>1</sup> Margaret Sommerville, “What would we lose by legalising euthanasia?” Accessed online 18/8/2014; <http://www.abc.net.au/religion/articles/2013/05/24/3766685.htm>

Netherlands, Dutch ethicist Henk Jochemsen states that, “The Dutch experience shows that once the termination of patients’ lives is practised and that practice wins official toleration or approval, the practice develops a dynamic of its own that resists effective control.”<sup>2</sup> Indeed, the Dutch experience has been such as to lead the ethicist Theo Boer to conclude that his previous support and assistance in regulating euthanasia in the Netherlands was a grave mistake.<sup>3</sup>

Belgium has had a similar experience since euthanasia was legalised in 2001. Commenting on the ongoing prevalence of killings without consent and the massive incidence of unregulated terminal sedation in Belgium, Professor Raphael Cohen-Almagor comments that, “fear of abuse is certainly relevant”.<sup>4</sup> Cohen-Almagor’s study demonstrates that it is no simple thing to enact and enforce exactly the kinds of requirements outlined in this Bill. The actual experience of obtaining informed consent and certifying the kinds of things that are being asked in the Bill, is far from simple, and physicians are frequently confused or give contradictory reports. This confusion creates opportunity for danger and corruption.<sup>5</sup>

As in the Netherlands, Belgium has also seen a rapid expansion in the legitimate candidates for euthanasia, including children and disabled infants.<sup>6</sup> “Slippery slope” arguments are only invalid if they are demonstrably alarmist and unrealistic. In this case, we can point to clear and documented examples where the slippery slope has fully manifested itself. As Henk Jochemsen and John Keown put it, “in less than a decade, the Dutch had slid down the slippery slope.”<sup>7</sup> Theo Boer likewise concludes, “Some slopes truly are slippery.”<sup>8</sup> The Australian Bill opens the door to just such expansion with its reference to a terminal illness without specifying a prognosis, and to “pain, suffering, distress or indignity to an extent unacceptable to the person” (§10). The evidence from Belgium and The Netherlands strongly suggests that this is dangerously under-specified, particularly the vague reference to “indignity” which opens the door to unanticipated and troubling expansions.

Cohen-Almagor’s findings about the problems with safeguards in Belgium and The Netherlands are especially relevant to the current Bill. In particular, he demonstrates that safeguards such as the provision for consultation by a second and third medical practitioner in §12(d) and (e) are unreliable. For instance, he cites evidence from The Netherlands and Belgium that such second consultations are sometimes done over the phone.<sup>9</sup> He also highlights the problems of physicians being acquainted. The Australian Bill specifies only that the first and second medical practitioners must not be related, employed by one another, or members of the same practice (§12.1(f)). Cohen-Almagor’s evidence suggests that this is wholly inadequate, and that there is real danger of tit-for-tat relationships developing between consultants.<sup>10</sup>

*Oregon.* Studies of the US state of Oregon have come to similar conclusions. One study found that “seemingly reasonable safeguards for the care and protection of terminally ill patients written into the Oregon law are being circumvented” and that “the implementation of the law has had unintended, harmful consequences for patients”.<sup>11</sup> Because of the similarity of the provisions in the legislation, I quote a longer excerpt from this study:

<sup>2</sup> H Jochemsen, “Euthanasia in Holland: an ethical critique of the new law”. *Journal of Medical Ethics* 1994; 20:212.

<sup>3</sup> Theo Boer, “We were wrong, says former regulator of Dutch euthanasia”, Accessed online 18/8/2014; <http://www.mercatornet.com/careful/view/14424>

<sup>4</sup> See Raphael Cohen-Almagor, “Euthanasia Policy and Practice in Belgium: Critical Observations and Suggestions for Improvement”, *Issues in Law & Medicine*, Volume 24, Number 3, 2009, 200.

<sup>5</sup> Cohen-Almagor, “Euthanasia Policy and Practice in Belgium”, 190.

<sup>6</sup> Eduard Verhagen, M. D., J.D., and Pieter J.J. Sauer, M.D., Ph.D. (2005). “The Groningen Protocol — Euthanasia in Severely Ill Newborns.” *NEJM* 352(10): 959-962.

<sup>7</sup> Henk Jochemsen and John Keown, “Voluntary euthanasia under control? Further empirical evidence from the Netherlands.” *Journal of Medical Ethics* 1999; 25: 20.

<sup>8</sup> Theo Boer, “We were wrong, says former regulator of Dutch euthanasia”, Accessed online 18/8/2014; <http://www.mercatornet.com/careful/view/14424>

<sup>9</sup> Cohen-Almagor, “Euthanasia Policy and Practice in Belgium”, 203.

<sup>10</sup> Cohen-Almagor, “Euthanasia Policy and Practice in Belgium”, 204.

<sup>11</sup> H. Hendin and K. Foley, “Physician-Assisted Suicide in Oregon: A Medical Perspective”, *Michigan Law Review* 106 (2008): 1613.

The Oregon law seems to require reasonable safeguards regarding the care of patients near the end of life, which include presenting patients with the option for palliative care; ensuring that patients are competent to make end-of-life decisions for themselves; limiting the procedure to patients who are terminally ill; ensuring the voluntariness of the request; obtaining a second opinion on the case; requiring the request to be persistent, i.e., made a second time after a two week interval; encouraging the involvement of the next of kin; and requiring physicians to inform OPHD of all cases in which they have written a prescription for the purpose of assisted suicide. The evidence strongly suggests that these safeguards are circumvented in ways that are harmful to patients.<sup>12</sup>

Amongst other things, this study highlights clear examples of people being pressured by family members into making requests.<sup>13</sup> The authors conclude that, "This particular case raises the question of what real meaning or value Oregon's prohibition of coercion has if it can be circumvented so easily."<sup>14</sup>

There are further dangers I could add to this evidence, such as the very real problem of doctors not actually knowing how to correctly carry out euthanasia procedures. One study of The Netherlands found widespread problems with the performance of euthanasia and PAS, including longer than expected times to death, failure to induce coma, and patients waking out of comas, unanticipated spasms and vomiting.<sup>15</sup> Similarly, Cohen-Almagor's studies have found that, "too few doctors knew how to correctly carry out euthanasia... Most physicians seemed unaware of procedures for guaranteeing a quick, peaceful, and certain death."<sup>16</sup>

The clear overall message of this evidence is that euthanasia and physician-assisted suicide are practices that simply cannot be adequately safeguarded against abuse and unacceptable difficulties. Other jurisdictions have tried safeguards very similar to those outlined in the Bill and they have not been adequate. Given the gravity of the issues at stake, in my opinion these problems mean that the Bill should be abandoned, and euthanasia and PAS should not be legalized.

### 3. Palliative care

*The Bill fails to adequately account for the reality of modern palliative care practice.*

Palliative care has seen significant advances in very recent years. In particular, there have been major advances in pain relief at the very end of life. These advances have not been adequately factored into the euthanasia debate. While the proposed Bill contains welcome provisions regarding palliative care, it still does not reflect the significance of these advances. Given that when it comes to the rights of the terminally ill, a right to palliative care has significant support, this issue constitutes a good reason to reject the Bill as it stands.

The central problem is that the reality of palliative care frequently makes a substantial difference to people's thinking about euthanasia or PAS; yet it only makes this difference when patients have the chance to experience it. A requirement to simply *discuss* palliative care, such as is contained within the draft Bill (§12.1.(h).(ii) and §12.2), is therefore manifestly inadequate.

A study in Sydney showed that the number of people requesting euthanasia in a palliative care service was 2.8% when they first presented for treatment, but fell to less than 1% once care was started. Less than 1% of patients persisted in their request for euthanasia.<sup>17</sup> Similar results have been found in Oregon. Oregon Psychiatry Professor Linda Ganzini and her colleagues report that as a result of palliative care, some patients in Oregon changed their minds about assisted suicide.

<sup>12</sup> H. Hendin and K. Foley, "Physician-Assisted Suicide in Oregon", 1614.

<sup>13</sup> Hendin and Foley, "Physician-Assisted Suicide in Oregon", 1624ff.

<sup>14</sup> Hendin and Foley, "Physician-Assisted Suicide in Oregon", 1625.

<sup>15</sup> Johanna H. Groenewoud et al., "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in The Netherlands", *New England Journal of Medicine* 342/8 (2000): 551-56.

<sup>16</sup> Cohen-Almagor, "Euthanasia Policy and Practice in Belgium", 207.

<sup>17</sup> P. A. Glare, "The euthanasia controversy. Decision-making in extreme cases," *MJA* 163 (1995): 558.

Among patients who requested PAS but then availed themselves of a substantive intervention by a physician (palliative care), 46% changed their minds about PAS.<sup>18</sup>

Furthermore, the problem is also that doctors themselves are largely uninformed about the realities and benefits of palliative care. This renders inadequate the seemingly reasonable requirement in §13.3 that a “dying with dignity service” must not be provided if the medical practitioner believes “there are palliative care options available to the person to alleviate the person’s pain or suffering to a level acceptable to the person”. This is too subjective a measure. The person will not be able to know whether this is the case without a trial. Given that such knowledge is beyond even the capability of palliative care specialists, the medical practitioner in question is certainly incapable of making this determination in advance of a trial.

Indeed, studies show that, “The more physicians know about palliative care, the less they favor assisted suicide; the less they know, the more they favor it.”<sup>19</sup> Some Dutch doctors have stated that if they had known previously what they now know about palliative care it would have changed the way they treated PAS patients.<sup>20</sup>

Other evidence suggests the reality of palliative care is not adequately factored in many jurisdictions thinking about euthanasia.<sup>21</sup> Moreover, this ignorance about modern palliative care undoubtedly means that public opinion about euthanasia is ill informed. If better knowledge of palliative care tends to make support for euthanasia and PAS fall so dramatically amongst those suffering from terminal illness, then the general ignorance of it ought to make us much less impressed by any purported support for euthanasia.

Here, again, I note the considered judgment of Cohen-Almagor:

Since 1991 I have been studying end-of-life issues. My research was not confined to libraries and research seminars. I visited dozens of hospitals and medical research centers in different countries: Israel, England, United States, Canada, Australia, New Zealand, the Netherlands, and Belgium. Most patients, according to testimonials of heads of departments and heads of ethics committees, cling to life no matter what. Even in the most miserable and painful situations, e.g. cancer, patients opt for life. This is hardly surprising given the alternative. In Jewish and Catholic hospitals I was told that 99 percent of patients cling to life. In less religious hospitals, 90 to 95 percent prefer to continue living. The majority of those who express a wish to die do this out of fear of suffering. Once physicians are able to control pain, many who had expressed a wish to die changed their minds. Thus we are left with a very small number of patients who wish to decide the moment of their death. These are strong-willed patients who emphasize autonomy and dignity. Medicine should serve all patients, not only the majority of them. But for the vast majority of patients, palliative care enjoys precedence over euthanasia. The two are not on equal footing. Only when palliative care fails to address the patient’s wishes and is unable to adequately mitigate the patient’s physical and mental suffering should physicians offer euthanasia.<sup>22</sup>

I do not wholly concur with the latter part of this judgment. I do not believe that euthanasia should ever become a legitimate option, for other reasons outlined here. However, the central point here is highly significant. At least until palliative care is better and more widely understood, euthanasia and PAS should not become a legal option.

#### 4. Particular problems

*There are significant problems with particular aspects of this Bill.*

Finally, I believe there are significant problems with particular aspects of the Bill. I will treat these in order.

<sup>18</sup> Linda Ganzini et al., “Physicians experience with the Oregon Death with Dignity Act”, 342; *New England Journal of Medicine* 557, 563 (2000).

<sup>19</sup> Hendin and Foley, “Physician-Assisted Suicide in Oregon”, 1635.

<sup>20</sup> Hendin and Foley, “Physician-Assisted Suicide in Oregon”, 1635.

<sup>21</sup> Cohen-Almagor, “Euthanasia Policy and Practice in Belgium”, 204–5.

<sup>22</sup> Cohen-Almagor, “Euthanasia Policy and Practice in Belgium”, 214.

### Part 1

*Section 4.* The definition of terminal illness makes no reference to a prognosis. This is extremely problematic, as it potentially makes euthanasia and PAS available to people who could live for a very long time. Some illnesses, for example prostate or breast cancer, diabetes or renal failure, and some injuries, for example paraplegia, can have prognoses of over a decade. That is, we are not necessarily talking about people who are imminently dying. This creates a real risk that the Bill will end up making suicide available to a far wider range of people than is intended. Furthermore, even in the instance of a terminally ill patient, it is well known in the medical community that the art of prognosis is extremely difficult and errors are often made.<sup>23</sup>

### Part 2

*Section 10.* The requirements outlined here are too broad. Indeed, the phrase “distress or indignity” is dangerously under-specified. One can imagine a wide range of complaints that might be described as “indignity”. Furthermore, section 12.(c).(iii) recognises that there may indeed be medical treatment available that can ameliorate this suffering. This further loosens the qualifying conditions in section 10, making it far too broad a category.

*Section 11.(2).(a).* I note and approve the right of a medical practitioner to refuse to provide a “dying with dignity” service.

*Section 12.(1).(c).(ii).* This is a problematic determination for a doctor to make without consulting a specialist in the problem. (See next point.)

*Section 12.(1).(d).* The requirement that this consultant either have qualifications *or experience* in treating the particular illness is dangerously undefined. What constitutes legitimate experience? This issue is particularly important given the evidence cited above that this consultation can easily be circumvented or improperly undertaken.

*Section 12.(1).(e).* The requirement to consult a psychiatrist is welcome, however, it has difficulties. It is not at all easy for a psychiatrist to make the kind of determination required here.<sup>24</sup> In Oregon, for example, 94% psychiatrists thought they would be unable to make this judgement from one consultation alone. Moreover, the requirement that the person not be suffering from “a treatable clinical depression in respect of the illness” is problematic; (a) because the “treatableness” of depression is a profoundly complex question; and (b) because the question of whether the depression is “in respect of the illness” is even more problematic. Depression is a complex disease which rarely has only one cause. Furthermore, even if the depression is not ‘in respect of this illness’, it can impair the patient’s judgment regarding the will to live.<sup>25</sup> The problems with this required consultation would make it almost useless as a safeguard.

*Section 12.(1).(f).* See comments under point 2, above, on physicians being acquainted.

*Section 12.(1).(h).(ii).* Again, I stress that simply informing someone about palliative care is inadequate. Palliative care needs to be experienced, as it is possible that both the patient and the doctor will be ignorant of its significance in the case at hand. See above under point 3. I do note with appreciation the requirement in Section 12.2 that this information must be given by a specialist in palliative care. However, I am concerned that this requirement could easily be avoided in practice, especially without rigorous oversight.

*Section 12.(1).(j).* In this and the following section, the first medical practitioner is being asked to make determinations that are too vaguely outlined to be meaningful checks. Yet they are extremely significant issues. In relation to (j), the requirement that the first medical practitioner be satisfied

<sup>23</sup> Viganò A, Dorgan M, Buckingham J, Bruera E, Suarez-Almazor ME. Survival prediction in terminal cancer patients: a systematic review of the medical literature. *Palliative Medicine*. 2000;14(5):363-74.

<sup>24</sup> S. Macleod, ‘Assisted dying in liberalised jurisdictions and the role of psychiatry: A clinician’s view’, *Australian and New Zealand Journal of Psychiatry* (2012):1-10, 7.

<sup>25</sup> Chochinov HM, Tataryn D, Clinch JJ, Dudgeon D. Will to live in the terminally ill. *The Lancet* 1999;354(9181):816-9.

that the person had considered their family, is too weak. In questions of euthanasia and PAS, there is a real risk of coercion from family members. It is impossible for a doctor to gauge the risk of coercion if they have not *themselves* consulted family members. As it stands, the requirement will not provide a meaningful safeguard.

*Section 12.(1).(k).* This clause is far too weak to be a meaningful check. This crucial provision relies far too much on the subjective judgment of one doctor, and they are given no significant guidance as to making the decision. There are no criteria specified as to what constitutes a decision taken “freely, voluntarily, and after due consideration”. As Cohen-Almagor has stressed in relation to other jurisdictions, “The law should specify a mechanism for ensuring that the request is voluntary”.<sup>26</sup> I do not believe this is a determination a single medical practitioner is qualified to make.

Here also, the issue of the influence of the medical practitioner is important. The terminally ill patient is in an extremely vulnerable position, and is at great risk of being pressured. They are especially vulnerable to the suggestions of their doctor.<sup>27</sup> Doctors must not be in a position where they themselves suggest euthanasia as a possible option for a patient. (This is different from a medical practitioner discussing euthanasia upon a patient’s request.<sup>28</sup>)

The reality is that the risk of elderly, infirm, burdensome people being pressured is extremely real. The requirement merely that the medical practitioner be satisfied that they have made the decision voluntarily is woefully inadequate.

*Section 12.(1).(l).* 7 days is too short a period. As has often been noted, “Patients attempting assisted suicide are usually ambivalent about dying; so too are patients requesting assisted suicide.”<sup>29</sup>

*Section 12.(1).(m).* The above objections to the adequacy of this safeguard apply here also, only more so, because in this case there is every chance that the second medical practitioner will not be well acquainted with the person, or the details of the case. Currently there is no objective criteria by which an assessment of voluntariness can be made.

*Section 12.(1).(o).* Again, this is too short a period of documented desire for euthanasia or physician-assisted suicide.

*Section 12.(1).(q).* I note with concern the lack of attention in the Bill to pharmaceutical regulation. It is dangerous to have lethal substances available in the community. Lethal drugs need to come from a central source and be reported both by the relevant medical practitioner and by the dispensing pharmacist, to provide a further check for physicians’ reporting. In at least one case in The Netherlands, drugs were used to kill a person other than the one for whom they were originally intended.<sup>30</sup>

---

<sup>26</sup> Cohen-Almagor, “Euthanasia Policy and Practice in Belgium”, 201.

<sup>27</sup> See Cohen-Almagor, “Euthanasia Policy and Practice in Belgium”, 213–14: “Much of the practice of euthanasia is dependent on the general practitioners. Physicians need to remain aware of the very powerful role their recommendations can play in people’s treatment choices, and of the undue ways their recommendations can influence patients. This is especially true when physicians and patients have long-standing relationships that span decades... We should recognize the compromising effect that the doctor’s initiation of discussion on euthanasia might have on the relationship with the patient and on the level of trust between the two parties, as well as on the patient’s mental framework.”

<sup>28</sup> See Cohen-Almagor, “Euthanasia Policy and Practice in Belgium”, 202: “The physician’s role is commonly understood as a healing role. With respect to professional ethics, talking about euthanasia upon a patient’s request is different from suggesting it to the patient. When a physician talks about the option of euthanasia upon the patient’s request, we are faced with the exceptional situation in which patient’s autonomy and the physician’s understanding of beneficence meet and manifest in the option of euthanasia. Thus, in this particular case, the healing model may be compromised in order to allow medical intervention based on a consensus between the patient and the physician in accordance with the principles of beneficence and patient autonomy. But when euthanasia is accentuated, the emphasis on euthanasia might undermine the patient’s voluntary wishes.”

<sup>29</sup> Hendin and Foley, “Physician-Assisted Suicide in Oregon”, 1622.

<sup>30</sup> Cohen-Almagor, “Euthanasia Policy and Practice in Belgium”, 215.

*Section 13.(1).(a).* I regard the mention of “appropriate medical standards” as a gratuitous evasion of the point made above, that what we are talking about represents a profound innovation in the practice of medicine.

*Section 13.(2).* In principle, I support the use of an interpreter. However, I believe that the interpreter must not be a member of the patient’s family.

*Section 13.(3).* This is an important recognition of palliative care. However, in our opinion, this clause actually undermines the basic assumptions of the Bill. In most cases, pain can in fact be managed. According to the World Health Organisation, there is readily available pain relief for up to 90% of patients before specialist services are obtained, after which there is an even higher percentage.<sup>31</sup> Here we meet again the problem of predicting the usefulness of palliative care without its being experienced. Much of the suffering that leads people to request euthanasia or physician-assisted suicide is psychological in nature.<sup>32</sup> It is impossible to predict in advance the impact of palliative care, and associated counseling, upon such suffering. This clause is therefore asking something largely impossible of the medical practitioner. It would be much better to require a trial of palliative care and counseling for everyone requesting euthanasia and PAS.

### *Part 3*

*Section 19.(a).* As mentioned above, there needs to be a longer *documented* period of desire for euthanasia or PAS. As it is, the properly documented period could be as short as 48 hours. This is unacceptably short.

*Section 20.* The requirements for reporting are, as they stand, inadequate. Too much is left to the diligence of the medical practitioner and there is no provision for review. Given the evidence outlined above about the prevalence of abuse, we regard this lack of accountability as a serious problem with the Bill. Methods to address this have been suggested in studies of other jurisdictions.<sup>33</sup>

*Section 24.* The immunity granted here is too generous given the gravity of the issues. Certainly, if euthanasia and PAS were legalised, doctors would need to be protected from criminal prosecution. However, this form of immunity is too much of a shield because it seems to create immunity from negligence as well. Given the documented incidence of problems and abuses in other jurisdictions, such a protection is extremely problematic. Hendin and Foley’s comment is relevant:

In professional practices a negligence standard based on objective, established medical guidelines is customary. If the intent of the assisted suicide law is to protect physicians from accountability for violating the statute’s provision, the good faith standard is ideal. But if the intent of the law is to provide protection for patients, a negligence standard would be more appropriate.<sup>34</sup>

## **Conclusion and Recommendations**

I do not believe that either euthanasia or PAS is ever a legitimate course of action for an individual or a doctor. However, I acknowledge that many others disagree on this point. In part, I believe this stems from a misunderstanding of the difference between euthanasia or PAS on the one hand, and on the other, palliative care decisions that ‘manage’ end-of-life care and the right of patients to refuse life-prolonging treatments. I also believe that there is a lack of familiarity with dying in our society that raises unnecessary fear of the dying process. Yet even if euthanasia and PAS were seen as legitimate, I do not believe they can be safely legislated. They cannot be adequately

<sup>31</sup> World Health Organization (1996): Cancer pain relief (2nd ed.) Geneva, 14.

<sup>32</sup> Hudson PL, Kristjanson LJ, Ashby M, Kelly B, Schofield P, Hudson R, et al. Desire for hastened death in patients with advanced disease and the evidence base of clinical guidelines: a systematic review. *Palliative Medicine*. 2006;20(7):693-701.

<sup>33</sup> Cohen-Almagor, “Euthanasia Policy and Practice in Belgium”, 215.

<sup>34</sup> Hendin and Foley, “Physician-Assisted Suicide in Oregon”, 1627.

safeguarded and inevitably expose some of the most vulnerable people in our society to unacceptable risks of abuse. I therefore believe that these practices should certainly not be legalised.

In conclusion, I reiterate my central argument that it would be far better not to proceed with this legislation at all. Misunderstandings about the realities of end of life care and death are rife, and we are still adjusting to the therapeutic significance of palliative care. Modern medicine affords better options than euthanasia and PAS, and these should be our choice as a community. I conclude with a timely warning from the Dutch ethicist, Theo Boer, who for nine years was a member of a regional review committee in The Netherlands, and who recently wrote to the UK advising against legalising euthanasia.

I used to be a supporter of legislation. But now, with twelve years of experience, I take a different view. At the very least, wait for an honest and intellectually satisfying analysis of the reasons behind the explosive increase in the numbers. Is it because the law should have had better safeguards? Or is it because the mere existence of such a law is an invitation to see assisted suicide and euthanasia as a normality instead of a last resort? Before those questions are answered, don't go there. Once the genie is out of the bottle, it is not likely to ever go back in again.<sup>35</sup>

### Further contact

The contact person for this submission is –

Dr Megan Best  
Palliative Care Department  
Greenwich Hospital  
PO Box 5084  
GREENWICH NSW 2065  
Email: [megan.best@sydney.edu.au](mailto:megan.best@sydney.edu.au)  
Mobile: 0434 823 678



Dr Glenn N Davies  
Archbishop of Sydney

21 August 2014

---

<sup>35</sup> Theo Boer, "We were wrong, says former regulator of Dutch euthanasia", Accessed online 18/8/2014; <http://www.mercatornet.com/careful/view/14424>