Doctors Opposed to Euthanasia

Letter to Members of the Tasmanian Parliament

Care of Parliament House
Salamanca Place
HOBART TAS 7000
Via email

18th May 2017

Dear Member of the Tasmanian Parliament,

We are writing to you regarding the *Voluntary Assisted Dying Bill 2016* soon to be debated in your parliament.

We note that the AMA has confirmed its opposition to this kind of legislation, and it will be no surprise to you that we also oppose it.

As we noted when we wrote to you at the time of the debate on 2013, we whole-heartedly affirm the general concept of 'Ending Life with Dignity'. Many of our members are directly involved in end-of-life care, either as Palliative Care physicians, doctors involved in the care of patients with cancer, or as doctors working in acute medical settings where patients frequently die. Our members are commonly involved in the care of patients where treatment is administered which may potentially inadvertently hasten death and where futile or unwanted treatment is withdrawn or not undertaken. However, we do not agree that euthanasia or assisted suicide should be considered a valid or licit means of achieving a dignified death.

We wish to comment on this Bill from two broad perspectives:

A. Some general comments about the need for such a Bill and its title and
B. Commentary of the details of the Bill, especially the difficulties with safeguards.

A. GENERAL COMMENTS

Our view is that, as described in a recent Medical Journal of Australia article ("Euthanasia and Physician Assisted Suicide: focus on the data" by Ezekiel Emanuel 10.5694/mja16.00132), the data would indicate that the main reasons people seek assisted suicide or euthanasia relate to fear and concerns about loss of control, not unrelieved pain (see also: Emanuel EJ et al. Lancet 1996; 347: Pages 1805-1810)

Furthermore, the recent Palliative Care Victoria submission to the Victorian Parliamentary Committee of Enquiry stated that the vast majority of patients with terminal pain can be adequately managed by current methods of care: (*In most cases, specialist palliative care teams are able to address the person's physical pain and other symptoms and to respond to their psycho-social, emotional, spiritual and cultural needs so that they are able to live and die well with dignity.*

However, a small minority of patients experience refractory symptoms……..Prudent application of palliative sedation therapy may be used in the care of selected palliative care patients with otherwise refractory distress.)

In other words we should note, as Emanuel recently observed in the MJA, "We should end the focus on the media frenzy about euthanasia and physical assisted suicide as if it were the panacea to improving end of life care. Instead, we need to focus on improving the care of most of the patients who are dying and need optimal symptom management at home."

In our view, legislation such as this does very little to improve the availability of palliative care skills and expertise in the medical and nursing community, nor does it provide expert palliative care teams, which is the primary community need.

Furthermore, it is our view that such legislation, once introduced, will almost inevitably be widened on the basis of people claiming "discrimination", and the indications will be expanded as in The Netherlands and Belgium. This has the effective consequence of creating assisted suicide as an "alternative form of medical treatment" which health economists will subsequently see to be remarkably cheaper than palliative care, or indeed, potentially curative treatments.

It should be noted that at the time of writing, psychiatric hospitals in Belgium have announced they will conduct euthanasia.

B. COMMENT ON THE SPECIFIC ASPECTS OF THE LEGISLATION

Essentially our view is that such "safeguards" are a legalistic attempt to address complex medical and psychological issues, which may involve not only the identified patient, but also the patient's family. Any attempt to solve these by legal means is fraught with difficulty.

Re Part 2. ELIGIBLE REQUESTS FOR ASSISTED DEATH

We note that Sections 8 and 9 launch directly into the provision of “assistance”, without recognizing the need for detailed assessment of any request for assisted suicide. In clinical practice, the careful doctor (GP or Physician or Psychiatrist) takes a request for suicide or euthanasia as an indication of an unsolved problem. In clinical practice this may be a person's anxiety about issues which may never arise, or fears about a difficulty which may arise but which may be quite amenable to palliative treatment. There may also be pressure from family members, or even indeed from healthcare professionals, that a person has a "duty to die", or in some circumstances there may be a financial conflict of interest.

It is of concern that there is no requirement for assessment by a Palliative Care Physician as to why a person is requesting assisted suicide.

Section 9. ELIGIBLE PERSON

Sub-section C refers to "the person has made an informed decision to end their life". We ask - What is indeed an informed decision? There is no requirement for an informed consultation with a specialist practitioner in the relevant area who can elicit, clarify and discuss the patient's specific fears or concerns. The term "informed decision" is remarkably vague.

Section 10. ELIGIBLE REQUEST

The thrust of this section is to determine "testamentary capacity". However, as we have observed, the issue is not simply a legal matter of testamentary capacity, but a clinical medical matter of why a person is making such a request.

Sub-section E refers to "an eligible medical condition". The questions arise as to a diagnosis by whom, and with what degree of documentation? We raise this matter because, when the Northern Territory Bill was in place, there were four deaths, and subsequently major consternation when it transpired that one of the people may not have been terminally ill. (REF: Kissane, Street, Nitschke, Lancet Vol 352, October 3, 1998).

Section 11. ELIGIBLE MEDICAL CONDITION

The phrase "advanced stages of a serious incurable and irreversible medical condition" encompasses a large variety of medical conditions. It should be noted that there is no requirement for the person to, in fact, be suffering from an illness which will be terminal in the short or medium term. The term "irreversible medical condition" would encompass a large variety of chronic illnesses which may not be terminal at all in the short or medium term. This opens the door to considerable abuse of these provisions.

Section 11 (1) B

Refers to "persistent suffering". Again, this is a very vague term. For example, an anxiety which may be "intolerable" initially may subsequently (by means of proper clarification and brief therapy by someone who is familiar with the condition both medical and psychological) become a quite manageable problem.

Similarly, "persistent suffering" is a very broad and ill-defined concept. A person may have a cancer pain problem for example, because:

1. they assume that cancer pain cannot be treated (incorrect);
2. they may have been prescribed analgesics, but do not take them because they believe "I should delay using them until the end"; (the doctor may not know that);
3. family members may be concerned the person will "become addicted", and urge them not to take the medication. (the doctor may not know that);
4. nursing practitioners unfamiliar with palliative care may tell a person that such medication will not be effective. (the doctor may not know that);
5. a person's general anxiety or depression difficulties may amplify the pain experience; and/or
6. they may never have had palliative care treatment.

The suffering that occurs in advanced illness is a multi-component experience which may consist of a variety of physical symptoms such as pain, but also include anxiety, fear of consequences, fear of medication, fear about the mode of death, depression and demoralisation and fear of being a burden to one's family.

Good palliative care involves the clarification of these various elements, and relief of them by not only medication, but also good medical psychotherapy. For example, many people in the

community incorrectly believe that cancer pain is untreatable, and may request euthanasia because of that.

When psychological issues are explored, the request for PAS may be withdrawn (Bannink, M., van Gool, A. R., van der Heide, A., *et al* (2000) Psychiatric consultation and quality of decision making in euthanasia. *Lancet*, 356, 2067 -2068.)

The clinical issues contributing to distress must be examined carefully, rather than a request for assisted suicide being accepted at face value. (Med J Aust. 1997 Feb 3; 166(3):150-2. Clinical issues in euthanasia. Zalcberg JR, Buchanan JD.

1 (ii) refers to "no reasonably available medical treatment or palliative care options". One may ask the question - How would a person know unless there is both a proper palliative care assessment and an adequate trial of palliative care treatment? This is vastly different from being simply told about palliative care and its likely benefits. Moreover, it would be a sad indictment upon Tasmanian society if ever a person sought euthanasia because such care was not available.

It is one thing to say to someone that "there are palliative care treatment options available", and another thing for a person to actually experience successful symptom control management, which of course could only be experienced by a trial period of such palliative treatment.

Section 12. INFORMED DECISION

It should be noted that a "primary medical practitioner" can, according to the Bill, be any medical practitioner who is registered for practice in Tasmania. We believe it is generally accepted that the ordinary general practitioner may not have extensive palliative care knowledge or skill. While generalist knowledge of Palliative Care is improving, Palliative Care Physicians receiving referrals from GPs will often comment that such referrals should have been made much earlier. Naturally a GP has to be a "master of all trades" and can have few numbers of patients or little practical experience in every medical specialty. Much remains to be done to assist GPs and to increase their understanding of what palliative care treatment may be available, or indeed, any other medical treatment, because the preconditions of eligibility for assisted suicide in this Bill refer to "any serious, incurable and irreversible medical condition", which would include a vast array of medical conditions.

Section 14. RESPONSIBILITY OF PRIMARY MEDICAL PRACTITIONER

We note that there is no requirement for involvement of the patient's main treating doctor. A patient may be under the care of a medical specialist for an ongoing chronic condition, and there is no requirement under the provisions of this Bill for that current treating specialist to be consulted, or to have any input into the accurate diagnosis and prognosis of the person's condition. How can any "primary medical practitioner" who has not previously been involved with the person's treatment have adequate information about the nature of their condition and an accurate prognosis?

Section 15. RESPONSIBILITIES OF PERSON PERFORMING COUNSELLING

The Bill makes no specific requirements as to the qualifications or training of a person who may perform "counselling". It would therefore be possible for a person to be referred to a

"psychotherapist", for example, for whom the State requires no particular training or qualifications. Any person can style themselves as a "psychotherapist". Similarly, but to a lesser degree, a person may be referred to a psychologist (registered or clinical) who has no training, expertise or experience in the medical condition under question. We have the view that the only person who would have such expertise would be what is known as a "Liaison Psychiatrist" - ie. a Psychiatrist who works in a medical setting and is familiar with both medical, psychological and psychiatric aspects of ongoing management of serious illness.

Section 15 (1) B

The counsellor is required to give an opinion essentially about testamentary capacity. However, there is no requirement for the person doing such counselling to have any professional qualifications at all. This is quite unacceptable in such a life and death matter.

Section 15 (3)

Notes that a person may, of course, be referred to a psychiatrist or psychologist, but it does not *require* for the person to be referred to a psychiatrist.

Furthermore, we would note that one purpose of any informed assessment from a psychological or psychiatric point of view would be an attempt to see if a person is being coerced in some way. People who have chronic or terminal illness are extremely vulnerable, and typically tend to believe that they are being a burden to their family and society. It is therefore extremely easy for a form of elder abuse to ensue (given that the majority of people who abuse elders are, in fact, their own family members). In recent times it has been recognized that there is a syndrome termed "early inheritance syndrome" where family members may, by their negative attitudes towards a person seriously ill, encourage such a person to request assisted suicide because they stand to benefit financially from the person's demise.

Section 19. RESPONSIBILITIES OF SECONDARY MEDICAL PRACTITIONER

There is a requirement that such a person be "independent", which seems to mean principally that they are not an employee/employer or supervisor, but in practice what would happen would be that a medical practitioner would refer to one of their colleagues who are of like mind. There is no requirement for true professional independence of assessment, or involvement of the patient's usual treating doctor or specialist, or requirement for consultation with a specialist in the relevant field, which may be a Specialist Physician or a Consultant Psychiatrist.

Section 24. ADMINISTRATION OF PRESCRIBED MEDICATION

As described in the recent MJA article by Emanuel, there is a common perception that people believe euthanasia and assisted suicide are flawless, quick and painless, and that "this belief is common, but mistaken". According to a study in The Netherlands in 2000, 5.5% of euthanasia and PAS had a technical problem, and 3.7% had a complication. An additional 6.9% of cases had problems with completing euthanasia or PAS. Reference Groenewoud JH et al "Clinical problems with the performance of euthanasia or physician assisted suicide in The Netherlands" NEJM 2000; 342:551-556. (NB: Two more recent cases from 2005 in Oregon are discussed at

https://dredf.org/public-policy/assisted-suicide/some-oregon-assisted-suicide-abuses-and-complications/#_ednref29)

There is no clarification in the Bill as to the process should a person have complications or awake from coma and their life *not* be terminated.

Section 28. RECORD REQUIREMENTS

There is no specification that deaths hastened by this means will be recorded by the Coroner as assisted suicide. If they are not recorded such, but recorded in the terms of the person's underlying chronic illness pathology, it will not be possible to subsequently examine accurately the operation of the Act.

Furthermore, there is no requirement to set up an overarching statutory body which supervises the operation of the Act, and provides publicly available statistics about it.

Section 33. FUNCTIONS AND POWERS OF REGISTRAR

There is no clarification about the nature of the qualifications of the Registrar, who is required to "review a death", "investigate, report, and make recommendations", etc. Is such a person to be a medical practitioner? How can a non-medically trained bureaucrat knowledgeably review and investigate without understanding the medical details of the circumstances.

Section 35. ANNUAL REPORT

There is no requirement for the report to include publicly accessible and informed statistics about the operation of the Act.

We urge you to reject this bill.

Yours sincerely,

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