

Doctors Opposed to Euthanasia

To: **Members of the South Australian House of Assembly**

Per email

24th September 2016

Dear Members of Parliament,

Re: Voluntary Euthanasia Bill 2016

We write to you, on behalf of Doctors Opposed to Euthanasia, to object, in the strongest terms possible, to the *Voluntary Euthanasia Bill 2016*, introduced by The Hon Steph Key MP.

We do not believe that the medical profession should ever be involved in the intentional killing of our patients. While we do not support this bill on principle, we also wish to offer you comment on the structure of this bill as examples of our firmly held opinion that no legislation can ever protect citizens sufficiently well for such a law ever to be considered.

The bill makes the only qualifying criteria (unbearable and hopeless suffering) for euthanasia or assisted suicide assessable only by the person themselves (section 4). We acknowledge that the question of unbearable and hopeless suffering is, indeed, highly subjective, however, subclause 12(1)(b) we are asked to satisfy ourselves as to 'unbearable and hopeless suffering'. All that we can do, in reality is to confirm that the person says that they are experiencing unbearable and hopeless suffering.

This is the dilemma with all legislation of this type. The Hon Steph Key MP has chosen to present a bill that opens up euthanasia and assisted suicide to all adult persons of sound mind who, by their own assessment, are experiencing unbearable and hopeless suffering.

The Belgian euthanasia law has a similar expression:

"- the patient is in a medically futile condition of constant and unbearable physical or mental suffering that can not be alleviated, resulting from a serious and incurable disorder caused by illness or accident."

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Beginning in 2002, the application of this law has since expanded. In 2014, the law was amended to include children. Euthanasia is now applied increasingly to psychiatric illness, to non-life threatening conditions and even Alzheimer's. Commentators observe that while the substantive clause (above) has not changed over time, the understanding of precisely what it means has, indeed, changed. In reality, the phrase 'unbearable and hopeless suffering' can, quite literally, mean almost anything. Certainly, the definitions given at 4(1) could include psychiatric issues as the 'medical condition'.

This draws us to ask the question: what do Members of Parliament and the South Australian public have in mind when they think of euthanasia and assisted suicide?

We would suggest, as is noted anecdotally from the time the law was passed in Belgium, that the notion that many people hold is of a very limited, last resort, situation when, perhaps, every possible intervention has been tried and there is nothing else that can be done.

The reality is something considerably different and that difference is noted well, in part, by the expressions in this bill. In Belgium, euthanasia is developing more as an 'early intervention':

In April 2015 the Journal of Bioethical Inquiry, published a paper entitled, *Between Palliative Care and Euthanasia* (Mortier, Leiva, Cohen-Almagor & Lemmens)¹ looking at the most recent euthanasia data from 2012-2013 from Belgium. They found that only 40 percent (1,283 out of 3,239) of the euthanized patients had a visit by a palliative care team, barely 12 percent (396 out of 3,239) had a visit by a palliative care specialist and just 9 percent (307 out of 3,239) were consulted by a psychiatrist.

The authors conclude that, "almost 40 percent of the patients who received euthanasia did not see a palliative care specialist nor interacted with a palliative care team."

Given that this bill adopts criteria similar to the Belgian model, we conclude that this is precisely the kind of licence this bill will provide; where people distressed by a diagnosis, possibly in fear of what the future may hold, may cite genuine 'unbearable and hopeless suffering' as a way of accessing euthanasia or assisted suicide without much if any consideration of other options and the possibility of many years of relative good health. Such persons may well include people with psychological suffering as is now the practice in both Holland and Belgium. What was once a 'last resort' option is now an 'early intervention'.

¹ Mortier, T., Leiva, R., Cohen-Almagor, R. et al. Bioethical Inquiry (2015) 12: 177. doi: 10.1007 / s11673-015-9635-7. Available at: <http://link.springer.com/article/10.1007/s11673-015-9635-7>

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Many doctors, we imagine, would refuse to process a euthanasia request for someone early on in their diagnosis in the knowledge that medical interventions may well be beneficial. But some may not, and the bill in question gives licence in such circumstances.

This is made all the more significant because we know from studies that the reasons given for requesting assisted suicide in both Oregon and Washington USA are more about fear of loss of autonomy, loss of control of bodily functions and enjoyment of life rather than any extant suffering or even future suffering.² These mostly existential issues can be addressed successfully, along with pain and symptom management, but the ‘normalisation’ of euthanasia overtime clearly changes things for a significant portion of the population, making conversations about care all the more difficult.

We wonder why this bill should consider details about methods of procuring death-by-doctor or assisted suicide (section 9) as ‘medical information’ and why subclause b should ever consider making legal under this bill the provision of equipment (not being a drug) for those purposes. Is this bill including, therefore, in the methods by which a person may access suicide or euthanasia, the various methods and equipment advocated for and supplied by organisations such as Exit International? This is grossly irresponsible.

We note that this month marks 20 years since the Euthanasia Laws Act was introduced into the Federal Parliament. That Act overturned to Northern Territory’s Rights of the Terminally Ill Act. The papers written by Professor David Kissane, psychiatrist, psycho-oncology researcher and palliative care physician on the brief operation of that Act in the Northern Territory make it very clear that even the best intentions of safeguards can and will be circumvented. At that time, palliative care as a multi-faceted discipline was in its infancy.


Twenty years on we confirm that our ability to successfully manage pain and symptoms has dramatically improved to the point where no-one need experience suffering at the end-of-life. We urge you to keep the focus on making such care available to all, on promoting well-being through public awareness of what good palliation brings to people in need and to shun the ethical and practical minefield that is euthanasia and assisted suicide.

² Washington State’s Report on 2015 notes concerns raised: Losing autonomy 86%; Less able to engage in activities making life enjoyable 86%; Loss of dignity 69%; Burden on family, friends/caregivers 52%; Losing control of bodily functions 49% Inadequate pain control or concern about it 35%. Report available at: <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2015.pdf>

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We do not support the passage of this bill and respectfully suggest that you, as one of our elected representatives, consider doing likewise.

Yours sincerely,



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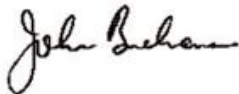
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For and on behalf of Doctors Opposed to Euthanasia

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