Care – or killing?
The euthanasia debate

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All proposals to legalise euthanasia or assisted suicide would create an exception to the laws which prohibit murder and assisting suicide.

Such proposals rely on the assertion of a "right to die" combined with the idea that some people would be "better off dead".

A right to die

Dr Philip Nitschke has claimed that everyone has a right to die:

… if we believe that there is a right to life, then we must accept that people have a right to dispose of that life whenever they want… So all people qualify, not just those with the training, knowledge, or resources to find out how to "give away" their life. And someone needs to provide this knowledge, training, or recourse necessary to anyone who wants it, including the depressed, the elderly bereaved, the troubled teen. If we are to remain consistent and we believe that the individual has the right to dispose of their life, we should not erect artificial barriers in the way of sub-groups who don't meet our criteria.[1]

Most proposals for legalised euthanasia specify initial restrictions as a deliberate tactic to attract the support of those MPs who are unwilling to endorse an unlimited right to die.

The Hon Robin Chapple, a Greens MLC who sponsored a euthanasia bill in Western Australia in 2010, told the WA Voluntary Euthanasia Society that:

… this is a very restrictive Bill. However, it was my intention to draft a restrictive Bill. This is because a restrictive law has the best chance of being passed by the current Western Australian Parliament. I know many readers will be disappointed that this Bill does not go further, does not apply to more people and does not allow for administration of euthanasia by a person other than a medical practitioner. But this law is a good start, and a step in the right direction.[2]

The history of euthanasia in the Netherlands is instructive.

In 1981 the courts allowed euthanasia only for those experiencing unbearable pain which could not be resolved in any other way.

In 1986 the Hague Court of Appeal explained that "unbearable pain" included "psychic suffering" or "the potential disfigurement of personality".

In 1993 the courts approved the killing of 50-year-old Hilly Bosscher, who said she wanted to die after the deaths of her two children and the breakup of her marriage.[3]

In 2002 the euthanasia statute only required that "*the patient's suffering is lasting and unbearable*". Children aged 16 or 17 can request euthanasia without parental agreement. Children aged 12 to 15 can be killed by euthanasia if they request it and a parent agrees.[4]

In February 2010 a Dutch group called Out of Free Will called for the law to allow anyone aged 70 or more who feels "tired of life" to request euthanasia.

For neurologist Swaab, death is straightforward. "Throughout the animal kingdom, individuals are simply replaced, rather than patched up endlessly," he explained. Aging constitutes nothing more than "cells wearing through use," Swaab said. His argument: when you feel you have no more life left in you, you should be able to say so, and act on it.[5]

A universal right to die is clearly incompatible with the view that suicide is always a tragedy and that everything possible should be done to help those contemplating suicide to find new hope and purpose in life.

Protecting the vulnerable

Euthanasia proponents may tactically concede that vulnerable people could be wrongly put to death, and seek to deal with this concern by stipulating procedural steps before a request for euthanasia can be acted upon.

High level inquiries have concluded that it is inherently impossible to adequately protect the vulnerable by such procedural steps.

United Kingdom

In 1994 the House of Lords Select Committee of Medical Ethics reported that society's prohibition of intentional killing should not be weakened because it "is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia." The committee concluded that it is not possible to set secure limits on voluntary euthanasia and that if a law permitting euthanasia were passed, then vulnerable people would feel pressure, whether real or imagined, to request early death. [6]

Canada

In 1995 in Canada, a Special Senate Committee on Euthanasia and Assisted Suicide recommended that assisted suicide and voluntary euthanasia remain criminal offences.

… legalization could result in abuses, especially with respect to the most vulnerable members of society. The ill and the frail are particularly dependent on those around them and on the health care system. Inevitably, and often without realizing it, these individuals cede control over their lives to the system and to those on whom they are dependent. For this reason, it would be difficult for others to assess whether an informed choice was made without coercion. If assisted suicide were legalized and accepted by the community, how could the expectations of the people surrounding the patient not influence his or her decision, particularly if the patient feels she or he is a burden on the family.

… some would feel pressured to resort to assisted suicide where financial and institutional resources are scarce. Financial restraints that affect the health care infrastructure could also result in attempts, perhaps unconsciously, to influence patients to die more quickly and conveniently. All of the above factors could make it difficult to establish whether a request for assisted suicide is voluntary.[7]

New York

The New York Task Force on Life and the Law in a 1997 supplement[8] to its 1994 report, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*,[9] helpfully summarised its views on the primary risks associated with the legalisation of assisted suicide or euthanasia as follows:

Undiagnosed or untreated mental illness

Many individuals who contemplate suicide – including those who are terminally ill – suffer from treatable mental disorders, most commonly clinical depression. Yet, physicians routinely fail to diagnose and treat these disorders, particularly among patients at the end of life. As such, if assisted suicide is legalised, many requests based on mental illness are likely to be granted, even though they do not reflect a competent, settled decision to die.

Improperly managed physical symptoms

Requests for assisted suicide are also highly correlated with unrelieved pain and other discomfort associated with physical illness. Despite significant advances in palliative care, the pain and discomfort that accompanies many physical illnesses are often grossly under-treated in current clinical practice. If assisted suicide is legalised, physicians are likely to grant requests for assisted suicide from patients in pain before all available options to relieve the patient's pain have been thoroughly explored.

Insufficient attention to the suffering and fears of dying patients

For some individuals with terminal or incurable diseases, suicide may appear to be the only solution to profound existential suffering, feelings of abandonment, or fears about the process of dying. While the provision of psychological, spiritual, and social supports can often address these concerns, many individuals do not receive these interventions. If physician-assisted suicide is legalised, many individuals are likely to seek the option because their suffering and fears have not adequately been addressed.

Vulnerability of socially marginalized groups

No matter how carefully any guidelines for physician-assisted suicide are framed, the practice will be implemented through the prism of social inequality and bias that characterises the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, isolated, members of a minority group, or who lack access to good medical care.

Devaluation of the lives of the disabled

A physician's reaction to a patient's request for suicide assistance is likely to depend heavily on the physician's perception of the patient's quality of life. Physicians, like the rest of society, may often devalue the quality of life of individuals with disabilities, and may therefore be particularly inclined to grant requests for suicide assistance from disabled patients.

Sense of obligation

The legalisation of assisted suicide would itself send a message that suicide is a socially acceptable response to terminal or incurable disease. Some patients are likely to feel pressured to take this option, particularly those who feel obligated to relieve their loved ones of the burden of care. Those patients who do not want to commit suicide may feel obligated to justify their decision to continue living.

Patient deference to physician recommendations

Physicians typically make recommendations about treatment options, and patients generally do what physicians recommend. Once a physician states or implies that assisted suicide would be "medically appropriate", some patients will feel that they have few, if any, alternatives but to accept the recommendation.

Increasing financial incentives to limit care

Physician-assisted suicide is far less expensive than palliative and supportive care at the end of life. Financial incentives to limit treatment may influence the way that the option of physician-assisted suicide is presented to patients, as well as the range of alternatives patients are able to obtain.

Arbitrariness of proposed limits

Once society authorises physician-assisted suicide for competent, terminally ill patients experiencing unrelievable suffering, it will be difficult, if not impossible, to contain the option to such a limited group. Individuals who are not competent, who are not terminally ill, or who cannot self-administer lethal drugs will also seek the option of physician-assisted death, and no principled basis will exist to deny them this right.

Impossibility of developing effective regulation

The clinical safeguards that have been proposed to prevent abuse and errors are unlikely to be realised in everyday medical practice. Moreover, the private nature of these decisions would undermine efforts to monitor physicians' behaviour to prevent mistakes and abuse. These profound dangers associated with legalising physician-assisted suicide outweigh any benefits which such a change in law might achieve in isolated cases.

Oregon

One procedural step proposed in euthanasia or assisted suicide bills is referral to a psychiatrist at the discretion of the medical practitioners assessing the person's request.

Under Oregon's *Death With Dignity Act,* referrals to psychiatrists have decreased significantly since the Act came into effect in 1998. In the first six years of the Act's operation (1998-2003), 30 out of 171 (18%) patients who took a lethal prescription were referred to a psychiatrist for assessment before the lethal drug was prescribed. In the next six years (2004-2009), only 8 out of 289 (3%) patients were referred. In 2009 not one patient out of 59 who took a lethal prescription under the provisions of the Act was referred to a psychiatrist before the lethal dose was prescribed.[10]

A case study on one patient, Michael Freeland, was presented at an American Psychiatric Association Annual Meeting Symposium on *Ethics and End-of-Life Care: New Insights and Challenges* in May 2004 by Gregory and Catherine Hamilton.[11]

Although Mr Freeland had an extensive history of depression and suicidal ideation prior to his diagnosis with a terminal illness, he was given a prescription for lethal medication by Dr Peter Reagan, an assisted-suicide advocate who was associated with the Compassion in Dying Federation. According to Mr Freeling's daughter, Dr Reagan commented that he did not think a psychiatric consultation would be necessary for Mr Freeland.

Fortunately Mr Freeland received support from other medical practitioners and from his daughter, so that he never took the lethal medication. He died peacefully some two years after first being prescribed it (even though Oregon law only allows prescription of lethal medication where death is likely within six months!).

The difficulty of adequately identifying and protecting patients with underlying mental health issues applies to all proposals for legalised euthanasia or assisted suicide.

Deadly days in Darwin

The *Rights of the Terminally Ill Act 1995* (the ROTI Act) was in operation in the Northern Territory from 1 July 1996 until it was suppressed by the Commonwealth's *Euthanasia Laws Act 1997* on 27 March 1997.

During the nine month period in which the ROTI Act was in effect and under its provisions, four people were assisted to terminate their lives by Dr Philip Nitschke.

Case studies on these four deaths and others who sought euthanasia have been published.[12] The principal author of this paper is Professor David Kissane, who is a consultant psychiatrist and professor of palliative medicine. Dr Philip Nitschke is a co-author of the paper.

The case studies examine how the conditions required by the ROTI Act were met. Cases numbered 3, 4, 5 and 6 in this paper refer to those cases which ended with the person's life being terminated with the assistance of Dr Nitschke.

Terminal illness and further treatment options

In one of the four cases, case 4, there was no consensus that the person was terminally ill. The person was diagnosed with mycosis fungoides.

One oncologist gave the patient's prognosis as 9 months, but a dermatologist and a local oncologist judged that she was not terminally ill. Other practitioners declined to give an opinion. In the end an orthopaedic surgeon certified that the ROTI provisions for terminal illness had been complied with.[13]

This was contrary to the requirement of the Act for a relevant specialist to certify that the patient was terminally ill. This violation was never investigated.

In case 3 the patient may have benefited from radiotherapy or strontium but neither of these was available in the Northern Territory.

In case 5, the patient had an obstruction and was clinically jaundiced. Section 7(1)(e) of the ROTI Act required Dr Nitschke as a "medical practitioner who receives a request" to have "informed the patient of the nature of the illness and its likely course, and the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures for keeping the patient alive, that might be available to the patient." However, Kissane reports that "when questioned about options like stenting for obstructive jaundice or the management of bowel obstruction", Dr Nitschke "acknowledged limited experience, not having been involved in the care for the dying before becoming involved with the ROTI Act."

This raises doubts as to whether the patient in this case – who was reported by Dr Nitschke to exhibit "indecisiveness" over a two month period about whether or not to request euthanasia – would still have done so if he had been given better symptomatic relief for the jaundice and obstruction.

"Severe pain or suffering"

Section 4 of the ROTI Act provided that: "A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient's medical practitioner to assist the patient to terminate the patient's life."

Section 7(1)(d) provided that "a medical practitioner may assist a patient to end his or her life" only if, among other conditions, "the illness is causing the patient severe pain or suffering".

Kissane reports that pain "was not a prominent clinical issue in our study". In case 3, "the patient took morphine for generalised bone pain." For case 4, "pain was well controlled". In case 5 the patient "complained of mild background pain incompletely relieved by medication". In case 6, "regular analgesia was needed for abdominal pain".

In none of these four cases is there any evidence of severe pain that was not being adequately controlled.

Other kinds of suffering or distress are reported. In case 3, these included "intermittent nausea, constipation, and diarrhoea" and "catheterisation". In case 4 the dominant problem was "pruritus". In case 5 there were symptoms associated with the obstructive jaundice, which seems to have been inadequately treated. In case 6 a key factor seemed to be patient's distress at "having witnessed" the death of her sister who also had breast cancer, "particularly the indignity of double incontinence". She "feared she would die in a similar manner". She "was also concerned about being a burden to her children, although her daughters were trained nurses".

Kissane noted that "fatigue, frailty, depression and other symptoms" – not pain – were the prominent concerns of those who received euthanasia. He observed that "palliative care facilities were underdeveloped in the Northern Territory, and patients in our study needed palliative care… There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care."

Clinical depression

From the case histories, it is apparent that cases 3 and 4 each had depressive symptoms.

In case 3, the patient had received "counselling and anti-depressant medication for several years". He spoke of feeling sometimes so suicidal that "if he had a gun he would have used it". He had outbursts in which he would "yell and scream, as intolerant as hell" and he "wept frequently".

Neither the patient's adult sons nor the members of the community palliative care team who were caring for him were told he was being assessed for euthanasia. "A psychiatrist from another state certified that no treatable clinical depression was present."

In case 4, "the psychiatrist noted that the patient showed reduced reactivity to her surroundings, lowered mood, hopelessness, resignation about her future, and a desire to die. He judged her depression consistent with her medical condition, adding that side-effects of her antidepressant medication, dozepin, may limit further increase in dose."

Kissane comments that "case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management." While Dr Nitschke "judged this patient as unlikely to respond to further treatment", Kissane, comments that "nonetheless, continued psychiatric care seemed warranted – a psychiatrist can have an active therapeutic role in ameliorating suffering rather than being used only as a gatekeeper to euthanasia".

Further concerns are raised by the report on case 5. Dr Nitschke reported that "on this occasion the psychiatrist phoned within 20 min, saying that this case was straightforward". This assessment took place on the day on which euthanasia was planned. This case involved an elderly, unmarried man who had migrated from England and had no relatives in Australia. Dr Nitschke recalled "his sadness over the man's loneliness and isolation as he administered euthanasia". Dr Nitschke has since revealed in testimony to a Senate committee, that he personally paid for this psychiatric consultation and that it in fact took less than 20 minutes.[14]

Demoralisation

Dr David Kissane, comments on the issue of demoralisation:

Review of these patients' stories highlighted for me the importance of demoralization as a significant mental state influencing the choices these patients made. They described the pointlessness of their lives, a loss of any worthwhile hope and meaning.

Their thoughts followed a typical pattern of thinking that appeared to be based on pessimism, sometimes exaggeration of their circumstances, all-or-nothing thinking in which only extremes could be thought about, negative self-labelling and they perceived themselves to be trapped in this predicament. Often socially isolated, their hopelessness led to a desire to die, sometimes as a harbinger of depression, but not always with development of a clinical depressive disorder. It is likely that … demoralized patients may not make a truly informed decision in giving medical consent.

Demoralization syndrome … is an important diagnosis to be made and actively treated during advanced cancer. It is recognised by the core phenomenology of hopelessness or meaninglessness about life. The prognostic language within oncology that designates 'there is no cure' is one potential cause of demoralization in these patients, a cause that can be avoided by more sensitive medical communication with the seriously ill. While truth telling is needed, hope must also be sustained so that life may be lived out as fully as possible. Patients with advanced cancer can be guided to focus on 'being' rather than 'doing', savouring the experiential moment of the present, so that purpose and meaning are preserved through inherent regard for the dignity of the person. Active treatment of a demoralized state by hospice services would involve counselling and a range of complementary therapies, use of community volunteers and family supports, all designed to counter isolation and restore meaning.[15]

A peaceful death?

Proponents of euthanasia and assisted suicide often speak about achieving a "gentle and peaceful death".

The annual reports on the operation of Oregon's *Death With Dignity Act* give a complication rate of 4.5% for regurgitation.

The interval from ingestion of lethal drugs to unconsciousness has been as long as 38 minutes.

The interval from ingestion to death has ranged from 1 minute to as long as 104 hours (4 days and 8 hours).

In 2005, one patient regained consciousness 65 hours after ingesting the medications, subsequently dying from his or her illness 14 days after awakening.[16]

In the Netherlands, technical problems occurred in 5% of cases. The most common were difficulty finding a vein in which to inject the drug and difficulty administering an oral medication.

Complications occurred in 3% of cases of euthanasia, including spasm or myoclonus (muscular twitching), cyanosis (blue colouring of the skin), nausea or vomiting, tachycardia (rapid heart beat), excessive production of mucus, hiccups, perspiration, and extreme gasping. In one case the patient's eyes remained open, and in another case, the patient sat up.

In 10% of cases the person took longer than expected to die (median 3 hours) with one person taking up to seven days.[17]

Better off dead

Alongside the demand for the right to die, euthanasia proposals also invoke the notion that some people would be better off dead.

So what is to be done about those who are considered better off dead but are unable to ask for euthanasia because they lack the required mental competence including children, the comatose, those with dementia and the intellectually disabled?

The Netherlands has dealt with this question by permitting children up to the age of 12, including newborns, to be killed by lethal injection with parental consent.

Additionally between 500 and 1000 people each year are given lethal injections without making an explicit request.[18]

Nitschke

If euthanasia were to be legalised anywhere in Australia, Dr Philip Nitschke would be the first to operate under the new law.

Given the analysis of the deaths for which he was responsible in the Northern Territory, this prospect gives grave cause for concern.

After the conviction of two women for the manslaughter of Alzheimer's sufferer Graham Wylie, Dr Nitschke reportedly said he "will urge Alzheimer's patients who contact his organisation, Exit International, not to go to a doctor, to avoid legal complications around their premature death".

In contrast to expert evidence given in court, Dr Nitschke asserted that: "Many people said this person [Wylie] knew what he was doing. I thought he knew what he was doing. Yet they [those giving expert evidence] base it on the medical evidence that he had lost his ability to make a decision, that he had lost his ability to say whether he could die or not. We'll be advising people not to [declare they have Alzheimer's]. Don't go to your doctor. Don't have the tests done. And if you do have the tests done that show that you're starting to lose mental capacity, make sure it is not recorded."[19]

There is no reason to trust Dr Nitschke's judgement as to whether a patient making a request for euthanasia is competent to do so or not.

Defeating euthanasia bills

Parliaments in Australia have in recent years rejected proposals for euthanasia or assisted suicide.

The *Medical Treatment (Physician Assisted Dying) Bill 2008* was defeated in Victoria's Legislative Council in September 2008 by 25-1.

The *Dying with Dignity Bill 2009* was defeated in Tasmania's House of Assembly by 15-7 after an inquiry into the Bill by the Joint Standing Committee on Community Development found that the Bill did not "provide an adequate or concise legislative framework to permit voluntary euthanasia/physician assisted suicide."

The *Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008* was defeated in South Australia's Legislative Council in December 2009 by 11-9.

The *Voluntary Euthanasia Bill 2010* was defeated in Western Australia's Legislative Council on 22 September 2010 by 24-11.

In speaking on the Western Australian bill the Hon Helen Bullock observed:

The Voluntary Euthanasia Bill raises the question of whether our election to Parliament gives us the right to sanction the killing of other human beings in circumstances other than self-defence or the defence of the nation. This is not a difficult question. The answer is simple. No. We do not have such a right. We do not have the right to sanction the killing of our fellow human beings. For that reason alone, I oppose the bill.[20]

Until all our elected representatives can be brought to share this simple conviction, the task is to persuade them that euthanasia and assisted suicide laws are unsafe and should not be passed.

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