EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE

Bills proposing the legalisation of physician-assisted suicide and euthanasia (if the person cannot take suicide tablets themselves) are currently being debated in the Victorian and NSW State Parliaments. A bill in Western Australia will soon be introduced. THESE BILLS REPRESENT A SERIOUS RISK TO VULNERABLE PEOPLE DUE TO THE INABILITY TO LEGISLATE IN A WAY THAT AVOIDS ABUSE.

The proposed model would require two doctors to agree to a person's request for a prescription for a lethal dose to be used to end the person's life. To do so the doctors essentially need to agree that the person would "be better off dead" or at least that it is reasonable for a person in that position to consider that he or she would be better off dead.

Definitions: Euthanasia describes an act where a doctor intentionally ends the life of a person by the administration of drugs, at that person's voluntary and competent request. Physician-assisted suicide describes the situation where a doctor intentionally helps a person to commit suicide by providing drugs for self-administration, at that person's voluntary and competent request. In the latter situation, the doctor is distanced from the act but morally it is the same as euthanasia as the motivation, intention and outcome are the same. BOTH REPRESENT RISKS TO SERIOUSLY ILL AND DISABLED PEOPLE.
Euthanasia is NOT: turning off life support, stopping life-prolonging treatment, or using (therapeutic) pain-killers and sedatives at the end of life. In these situations the AIM is not to kill the patient, but to reduce suffering and allow the underlying disease to progress to natural death. These are good medical practices which are already legal and ethical choices.

RISKS OF EUTHANSIA LEGISLATION

1. It legitimises suicide as a solution to life's problems. In jurisdictions where euthanasia and physician-assisted suicide (EPAS) are legal, unassisted suicide rates are also rising. We already have a suicide crisis in Australia, with over 8 people per day taking their lives. We should not introduce government-sanctified suicide as well.

2. It changes one of the most basic tenets of our society, that we do not kill one another, even for reasons of mercy and compassion. This is a fundamental value that recognises that all human life should be respected, and that all innocent lives will be protected by the state. Also that all lives are worth living.

3. Legislators have proposed introducing EPAS as part of standard medical practice, in an attempt to confer medical legitimacy on the practice. However it is fundamentally opposed to medical ethics, 'first, do no harm', and should not be confused with the role of the doctor as healer. This is a risk to the doctor-patient relationship which is based on trust.

4. This is not a debate about the failure of medicine or physical suffering. This timing of the debate, when we have more medical treatments than ever before in human history, makes this clear. We know that in places where EPAS is legal, psychosocial reasons, such as fear of the future and fear of losing autonomy, are prominent motivators for requesting EPAS. This suggests that the way to ease public distress about dying would be by providing more

psychosocial support for dying people, by increasing palliative care availability and the multidisciplinary support that accompanies it. Furthermore, research shows that most euthanasia requests are a cry for help, misinterpreted by doctors, rather than an actual desire to be killed. Commentators in Oregon, USA, have reported cases of this misinterpretation leading to hastened death.

4. In all jurisdictions where EPAS has been legalised, there have been abuses documented that include the following:

- Allowing EPAS for people who have untreated depression. A desire for hastened death is a symptom of depression which should be treated rather than providing the person with suicide pills. Psychologists are not trained to diagnose depression.
- Allowing EPAS for people who feel coerced into requesting it when it is not what they really want. There is no way to protect against the feeling of a sick person that they are a burden to their carers, whether the carers make this felt overtly or unconsciously. Furthermore, a recent report on Elder Abuse in NSW noted that abuse is frequent, and that financial abuse from a family member is the most common form.
- Allowing EPAS for people who are not mentally competent. Assessing mental competence is a complicated procedure that requires significant time investment and expertise. Australian psychiatrists have described an inability to definitely establish mental competence in one consultation.
- Allowing EPAS to occur without independent supervision to ensure that suicide pills are taken voluntarily.
- Extending EPAS to other categories of patient over time on the grounds that the right to EPAS cannot be limited on the basis of source of subjective suffering.
- Allowing EPAS who do not really qualify for access under the law due to errors in assessing prognosis (how long someone has to live). This assessment is notoriously difficult. Everyone knows someone who has outlived their prognosis.

NONE OF THESE ABUSES CAN BE AVOIDED IN THE CURRENT LEGISLATION.

5. EPAS is advertised as a way to a peaceful death, but research shows that up to 25% of cases of EPAS involve complications such as vomiting up the pills, and swallowing the vomit, and waking up after a period of being unconscious, or being unable to administer the medicine. Palliative care is a much more reliable way of ensuring a peaceful death.

PLEASE CONTACT MEMBERS OF OUR STATE PARLIAMENTS TO ASK THEM TO VOTE AGAINST A CHANGE IN THE LAW TO ALLOW EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE.

Information on politician contact details, references and details for the above points, and letter templates are available at http://www.healthprofessionalssayno.info/