ANZSPM

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Position Statement

The Practice of Euthanasia and Assisted Suicide

Preamble

At the date of approval of this document, it is acknowledged that the practices of euthanasia and assisted suicide are illegal acts in both Australia and New Zealand.

Background

The Australian and New Zealand Society of Palliative Medicine Incorporated (ANZSPM) is a specialty medical society that facilitates professional development and support for its members. ANZSPM promotes the discipline and practice of Palliative Medicine in order to improve the quality of care of patients with palliative diagnoses, and support their families.

ANZSPM members are medical practitioners. They include Palliative Medicine **S**pecialists, doctors training in the Palliative Medicine discipline, General Practitioners (GPs) and doctors who are specialists in other disciplines such as oncology.

Purpose

The purpose of this position statement is to state that:

(a) The discipline of Palliative Medicine does not include the practice of euthanasia or assisted suicide;

(b) ANZSPM endorses the **World Medical Association Resolution on Euthanasia,** *adopted by the 53rd WMA General Assembly, Washington, DC, USA, October 2002,* which states:

> "The World Medical Association reaffirms its strong belief that euthanasia is in conflict with basic ethical principles of medical practice, and
>
> The World Medical Association strongly encourages all National Medical Associations and physicians to refrain from participating in euthanasia, even if national law allows it or decriminalizes it under certain conditions."[1]

(c) ANZSPM opposes the legalisation of both euthanasia and assisted suicide.

Definitions

Palliative Medicine is the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life.[2]

Palliative Care as defined by the World Health Organization[3] is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care provides relief from pain and other distressing symptoms; it

- Affirms life and regards dying as a normal process;
- Intends neither to hasten nor postpone death;
- Integrates the psychological and spiritual aspects of patient care;
- Offers a support system to help patients live as actively as possible until death;
- Offers a support system to help the family cope during the patient's illness and in their own bereavement;
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- Enhances quality of life, and may also positively influence the course of illness; and
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

[1] http://www.wma.net/en/30publications/10policies/e13b/index.html, Accessed 20/12/2012

[2] Pallipedia: http://pallipedia.org/glossary/term.php?id=196. Accessed on 11 October 2009

[3] WHO (2002) http://www.who.int/cancer/palliative/definition/en/. Accessed on 11 October 2009

Euthanasia is the act of intentionally, knowingly and directly causing the death of a patient, at the request of the patient, with the intention of relieving intractable suffering. If someone other than the person who dies performs the last act, euthanasia has occurred.[4]

Assisted suicide is the act of intentionally, knowingly and directly providing the means of death to another person, at the request of the patient, with the intention of relieving intractable suffering, in order that that person can use that means to commit suicide. If the person who dies performs the last act, assisted suicide has occurred.[5]

Statement

1. The Palliative Medicine discipline does not include the practice of euthanasia or assisted suicide. ANZSPM activities are limited to the Palliative Medicine discipline. There is a clear distinction between good care for the dying and active interventions instituted in order to deliberately end the life of a patient.
2. Patients have the right to refuse life sustaining treatments including the provision of medically assisted nutrition and/or hydration. Refusing such treatment does not constitute euthanasia.
3. Good medical practice mandates that the ethical principles of beneficence and non-maleficence should be followed at all times. The benefits and harms of any treatments (including the provision of medically assisted nutrition and/or hydration) should be considered before instituting such treatments. The benefits and harms of continuing treatments previously commenced should be regularly reviewed. Withholding or withdrawing treatments that are not benefitting the patient, is not euthanasia.
4. Treatment that is appropriately titrated to relieve symptoms and has a secondary and unintended consequence of hastening death, is not euthanasia.
5. Palliative sedation for the management of refractory symptoms is not euthanasia.[6]
6. Requests for euthanasia or assisted suicide should be acknowledged with respect and be extensively explored in order to understand, appropriately address and if possible remedy the underlying difficulties that gave rise to the request. Appropriate ongoing care consistent with the goals of Palliative Medicine should continue to be offered.

[4] Adapted from International Task Force on Euthanasia www.internationaltaskforce.org/definitions.htm. Accessed 11 October 2009
[5] Adapted from the International Task Force on Euthanasia www.internationaltaskforce.org/definitions.htm. Accessed 11 October 2009
[6] http://www.biomedcentral.com/1472-684X/9/20, European Association for Palliative Care (EAPC) framework for palliative sedation: an ethical discussion, Accessed 8/3/2013.

7. When requests for euthanasia or assisted suicide arise, particular attention should be given to gaining good symptom control, especially of those symptoms that research has highlighted may commonly be associated with a serious and sustained "desire for death" (e.g. depressive disorders and poorly controlled pain). In such situations early referral to an appropriate specialist should be considered.[7] [8]
8. Despite the best that Palliative Care can offer to support patients in their suffering, appropriate specialist Palliative Care to remedy physical, psychological and spiritual difficulties may not relieve all suffering at all times.
9. ANZSPM acknowledges the significant deficits in the provision of palliative care in Australia and New Zealand, especially for patients with non-malignant life limiting illnesses, those who live in rural and remote areas, residents of Residential Aged Care Facilities, the indigenous populations and those from culturally and linguistically diverse backgrounds.
10. ANZSPM advocates for health reform programs in Australia and New Zealand to strengthen end of life care by remedying shortages in the palliative care workforce (including in the specialist medical, nursing, and allied health fields), ensuring improved access to appropriate facilities and emphasising the role of advance care plans and directives.
11. ANZSPM advocates for increased carer support for respite care to decrease the sense of burden for many patients at the end of life.

[7] Breitbart W. Suicide risk and pain in cancer and AIDS patients. In: Chapman CR, Foley KM, eds. Current and Emerging Issues in Cancer Pain: Research and Practice. New York, NY: Raven Press; 1993:49-65.
[8] Chochinov HM, Wilson KG. The euthanasia debate: attitudes, practices and psychiatric considerations. Can J Psychiatry. 1995;40:593-602.