THE UNIVERSITY OF
NOTRE DAME
AUSTRALIA

2nd April 2008

Committee Secretary
Senate Legal and Constitutional Affairs Committee
Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Dear Sir or Madam,

Submission re “Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008”.

As a practicing palliative care physician, I wish to take this opportunity to express my grave concern at the plans to readdress this bill. My reactions are based on my current and previous professional experiences as a physician, researcher and academic in palliative medicine and as a concerned member of our humane society.

Firstly, the rights of the terminally ill to choose the timing of their own death are much debated. In a select number of places around the world, people are legally able to prematurely terminate their lives either by euthanasia or physician-assisted suicide. It is very notable at the times the laws were enacted in the Netherlands, Oregon (USA) and Belgium that specialist palliative care was underdeveloped. It is therefore very notable that when government-funded research five years after legalisation of assisted-euthanasia in the Netherlands evaluated the effect of the 2002 euthanasia laws, it was shown that the number of cases of euthanasia fell. Similar falls were noted in the requests for euthanasia and assisted suicide. Over this same time, improvements in the Netherlands were made to improve the practice and delivery of specialist palliative care services, with numbers of physicians undertaking education to provide better end of life care (1).

Secondly, it is clear from reports in medical literature that some of the requests for physician-assisted suicide stem from people’s fears and concerns that they may become a burden to those around them. Common characteristics of those who request premature termination of life include people with strong personalities, higher levels of education, often holding positions of responsibility before they became unwell and who report they find the dependant role intolerable. Other reasons that have been reported include depression, disillusionment and helplessness (2). Although often cited as one of the main reasons that people ask for death, uncontrolled symptoms do not feature prominently when the available data is objectively reviewed. In contrast, the fear of developing uncontrolled symptoms does (3). The longer that requests for assisted-death are made before the actual death, the more entrenched the desire seems to become (4). One solution to this suffering that has been offered is to provide practical strategies to support people without placing extra burdens on their families. This may ease the concerns of terminally ill people (5), whilst allowing them to live as long and as well as possible.

Thirdly, a request for assisted suicide may be made at the time a person has first confronted the reality of their imminent mortality and then verbally expressed it. Requests for physician-assisted suicide and euthanasia are commonly made to palliative care professionals, but are often used by people as a method of expressing and communicating their suffering. Furthermore, it may be a test that the sick person uses to try and gauge how others value the sick person's worth. This discussion, for many people, may be the first opportunity they have had to engage in an open discussion about the processes of dying, exploring myths, realities, fears and concerns (6, 7). This is an opportunity often welcomed by the dying person, but feared by friends and families, with death commonly viewed as a failure of health technology and a rare event. Open and frank conversations may allow the dying person the independence they desire to make autonomous decisions about life-prolonging treatments, care around the time of death and decisions about the place of death to be made.

Fourthly, I know that in some people the process of dying is anguished and painful. However, these experiences are so rare as to remain memorable in a clinician's mind. For these people, best care delivered from the highest possible evidence base needs to be readily and freely available. It is the intolerable reality of current Australia that all Australians do not have equitable access to this care. It is my belief that rather than launching campaigns to shorten life, a more worthwhile use of respected resources would be to lobby strongly for more a just distribution of specialist palliative care, practiced from the strongest evidence possible. Regardless of whether or not a request for termination of life is made, the rights of the terminally ill must surely include the access to skilled care if or when it is needed.

Finally, life has a 100% chance of mortality. However, this statistic in no way lessens the respect for life and all people have the right to live as well as possible until the inevitable time of their death. Regardless of the duration of life, every person has equal worth and all have the capacity to contribute in their unique way up to the time of their death. Any notion that caring for dying people is burdensome is abhorrent and horribly wrong. As it is a professional pleasure to be present when people are born, it is also an immense privilege to care for people at the end of their lives. To correlate a "good death" with a deliberately shortened life seems the antithesis of caring and an expression of immense disrespect.

Yours sincerely,

Dr Katherine Clark
MB BS MMed (pain) FRACP FAChPM
Senior Lecturer
School of Medicine
The University of Notre Dame Australia

References:

1. Sheldon T. Incidence of euthanasia in the Netherlands falls as that of palliative sedation rises. BMJ 334(7603):1075, 2007 May 26
2. Finlay V, Wheatley J, Izdebski C. The House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill: Implications for Specialist Palliative Care. Palliative Medicine 2005;19:444453
3. Hudson PL. Kristjanson LJ. Ashby M. Kelly B. Schofield P. Hudson R. Aranda S. O'Connor M. Street A. Desire for hastened death in patients with advanced disease and the evidence base of clinical guidelines: a systematic review. Palliative Medicine. 20(7):693-701, 2006 Oct.
4. Wilson KG. Chochinov HM. McPherson CJ. Skirko MG. Allard P. Chary S. Gagnon PR. Macmillan K. De Luca M. O'Shea F. Kuhl D. Fainsinger RL. Karam AM. Clinch JJ. Desire for euthanasia or physician-assisted suicide in palliative cancer care. Health Psychology. 26(3):314-23, 2007 May.
5. Ganzini L. Goy ER. Dobscha SK. Why Oregon patients request assisted death: family members' views. Journal of General Internal Medicine. 23(2):154-7, 2008 Feb.
6. Mak Y, Elwyn G. Voices of the terminally ill: uncovering the desire for euthanasia. Palliative Medicine
7. Back AL. Starks H. Hsu C. Gordon JR. Bharucha A. Pearlman RA. Clinician-patient interactions about requests for physician-assisted suicide: a patient and family view. Archives of Internal Medicine. 162(11):1257-65, 2002 Jun 10.