New Testament House Churches

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7 April 2008

The Secretary,
Senate Committee on Legal and Constitutional Affairs
Parliament House
Canberra, ACT, 2600

Dear Sir/Madam,

Inquiry into the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008

Our submission to the enquiry is attached. It is an article by Dr Peter Saunders, BHB, MBChB, FRACS.

We oppose the legalisation of euthanasia for the reasons given by Dr Saunders and urge the Committee to do likewise.

Yours faithfully,

Richard Eason

(A signed copy will be delivered by hand later today)

12 Reasons Why Euthanasia Should Not Be Legalised

by Dr Peter James Saunders BHB, MBChB, FRACS

1 Voluntary euthanasia is unnecessary because alternative treatments exist.

IT IS WIDELY BELIEVED that there are only two options open to patients with terminal illness: either they die slowly in unrelieved suffering or they receive euthanasia. In fact, there is a middle way, that of creative and compassionate caring , Meticulous research in palliative medicine has in recent years shown that virtually all unpleasant symptoms experienced in the process of terminal illness can be either relieved or substantially alleviated by techniques already available.

This has had its practical expression in the hospice movement, which has enabled patients' symptoms to be managed either at home or in the context of a caring in-patient facility . It is no surprise that in the Netherlands where euthanasia is now accepted there is only a very rudimentary hospice movement. By contrast, in the UK, which has well developed facilities to care specifically for the terminally ill, a House of Lords committee recently ruled that there. should be no change in the law to allow euthanasia.

This is not to deny that there are many patients presently dying in homes and hospitals who are not benefiting from these advances . There are indeed many having sub-optimal care. This is usually because facilities do not exist in the immediate area or because local medical practitioners lack the training and skill necessary to manage terminally ill patients properly. The solution to this is to make appropriate and effective care and training more widely available, not to give doctors the easy option of euthanasia. A law enabling euthanasia will undermine individual and corporate incentives for creative caring.

2 Requests for voluntary euthanasia are rarely free and voluntary.

A PATIENT WITH an illness is vulnerable. He lacks the knowledge and skills to alleviate his own symptoms, and may well be suffering from fear about the future and about the effect his illness is having on others. It is very difficult for him to be entirely objective about his own situation. Those who regularly manage terminally ill patients recognise that they often suffer from depression or a false sense of worthlessness which may affect their judgement. Their decision-making may equally be affected by confusion, dementia, or troublesome symptoms which could be relieved with appropriate treatment. Patients who on admission say 'Let me die.' usually after effective symptom relief are most grateful that their request was not acceded to. Terminally ill patients also adapt to a level of disability that they would not have previously anticipated they could live with. They come to value what little quality of life they have left.

Many elderly people already feel a burden to family, careers and a society which is cost-conscious and may be short of resources. They may feel great pressure to request euthanasia "freely and voluntarily" . These patients need to hear that they are valued and loved as they are. They need to know that we are committed first and foremost to their well-being, even if it does involve expenditure of time and money. The way we treat the weakest and most vulnerable people speaks volumes about the kind of society we are.

3 Voluntary euthanasia denies patients the final stage of growth.

IT IS DURING THE TIME OF A terminal illness that people have a unique opportunity to reflect on the way they have lived their lives, to make amends for wrongs done, to provide for

the future security of loved ones, and to prepare mentally and spiritually for their own death. Not all make full use of this opportunity, but those involved in hospice work often observe a mending of family relationships and rediscovery of mutual love and responsibility that may not have been evident for years.

It is often through facing the hardship that terminal illness brings, and through learning to accept the practical help of others that human character and maturity develops most fully. Death if properly managed can be the final stage of growth. It can also be a time when words are spoken and strength imparted that will help sustain "those left behind" through the years ahead.
Losing the opportunity of caring for vulnerable people denies us an essential part of our humanity. We conquer suffering , not by being insulated from its realities, but by facing it. Voluntary euthanasia, by artificially shortening life, denies these possibilities.

4 Voluntary euthanasia undermines medical research.

One of the major driving forces behind the exceptional medical advances made this century has been the desire to develop treatments for previously fatal illnesses, and the eagerness to alleviate hitherto unmanageable symptoms. Medical research is essential if medicine is to advance further. When the focus changes from curing the condition to killing the individual with the condition this whole process is threatened. The increasing acceptance of prenatal diagnosis and abortion for conditions like spina bifida, Down's syndrome and cystic fibrosis is threatening the very dramatic progress made in the management of these conditions, especially over the last two decades. Rather than being employed to care and console, funds are being diverted to fuel the strategy of "search and destroy".

If euthanasia is legalised we can expect advances in kentoloqv (the science of killing) at the expense of treatment and symptom control. This will in turn encourage further calls for euthanasia.

5 Hard cases make bad laws.

LEGISLATION OF euthanasia is usually championed by those who have witnessed a loved one die in unpleasant circumstances, often without the benefits of optimal palliative care. This leads to demands for a "right to die." In reality, the slogan is misleading. What we are considering is not the right to die at all, but rather the right to be killed by a doctor; more specifically, we are talking of giving doctors a legal right to kill. This has its own dangers which we shall consider shortly.

Allowing difficult cases to create a precedent for legalised killing is the wrong response. We need rather to evaluate these difficult cases so that we can do better in the future. This was clearly demonstrated in the case of Nigel Cox, the Winchester rheurnatologist found guilty of attempted murder after giving a patient with rheumatoid arthritis a lethal injection of potassium chloride in August 1991. Had he been willing to consult those who specialise in pain management, he could have relieved his pa tient's symptoms without killing her. If errors of omission are acknowledged, changes can be made.

The European Association for Palliative Care recently registered its strong opposition to the legalisation of euthanasia. If care is aimed at achieving "The best possible quality of life for patients and their families" by focusing on a patient's physical, psychosocial and spiritual suffering, requests for euthanasia are extremely uncommon.
The answer is not to change the law, but rather to improve our standards of care.

6 Autonomy is important but never absolute.

AUTONOMY IS IMPORTANT We all value the opportunity of living in a free society, but also recognise that personal autonomy has its limits. Rights need protection, but must be balanced against responsibilities and restrictions if we are to be truly free.
'We are not free to do things which limit or violate the reasonable freedoms of others. No man is an island. No person makes the decision to end his or her life in isolation. There are others who are affected: friends and relatives left behind and the health-care staff involved in the decision-making process.

Western society no longer recognises suicide as a crime, but still appreciates that a person's decision to take his or her life can have profound, often life-long effects on the lives of others. There may be guilt, anger or bitterness felt by those left behind. Personal autonomy is never absolute. The effect of personal decisions on others now living or in future generations must also be considered.

7 Voluntary euthanasia leads to euthanasia tourism.

ONCE VOLUNTARY euthanasia is legalised in a single country or state, people from neighbouring constituencies will take advantage of it . In this way, no territory can act in isolation. The decisions we make have implications for other nations, not only for their citizens who choose "euthanasia tourism", but also for future changes in their own laws. Any state considering a change in its laws in this regard has a responsibility not just to its own citizens but to the whole international community.

8 Voluntary euthanasia changes the public conscience.

THE LAW IS A VERY powerful educator of the public s i n . When a practice becomes legal. accepted and widely practised in society, people cease to have strong feeling's about it. This was most dramatically demonstrated in Nazi Germany. Many of those involved in the euthanasia programme there were doctors who were motivated initially by compassion for their victims. Their consciences, and that of the society which allowed them to do what they did, became numbed. The testimony at Nuremberg of Karl Brandt, the medic responsible for coordinating the German euthanasia programme, is a chilling reminder of how conscience can gradually change:

"My underlying motive was the desire to help individuals who could not help themselves . . . such considerations should not be regarded as inhuman. Nor did I feel it in any way to be unethical or immoral.... I am convinced that if Hippocrates were alive today he would change the wording of the oath ... in which a doctor is forbidden to administer poison to an invalid even on demand. I have a perfectly clear conscience about the part I played in the affair. I an perfectly conscious that when I said 'Yes' to euthanasia I did so with the greatest conviction. just as it is my conscience today that it is right."4

He sincerely believed he was innocent. This demonstrates that once doctors start killing it is possible for them to go on doing it without feeling any guilt.

9 Voluntary euthanasia violates historically accepted codes of medical ethics.

TRADITIONAL MEDICAL ethical codes have never sanctioned euthanasia, even on request for compassionate motives. The Hippocratic Oath states, "I will give no deadly medicine to anyone if asked, nor suggest such counsel The international Code of Medical Ethics, as originally adopted by the World Medical Association in 1949 in response to the Nazi holocaust, declares 'a doctor must always bear in mind the obligation of preserving human life from the time of conception until death'. In its 1992 Statement of Marbella, the World Medical Association6 confirmed that assisted suicide, like euthanasia, is unethical and must

be condemned by the medical profession.. When a doctor intentionally and deliberately enables an individual to end his life, the doctor acts unethically.

10 Gives too much power to doctors.

CALLS FOR VOLUNTARY euthanasia have been encouraged either by the failure of doctors to provide adequate symptom control, or by their insistence on providing inappropriate and meddlesome interventions which neither lengthen life nor improve its quality. This has understandably provoked a distrust of doctors by patients who feel that they are being neglected or exploited. The natural reaction is to seek to make doctors more accountable.
Ironically, voluntary euthanasia legislation makes doctors less accountable4 and gives them more power. Patients generally decide in favour of euthanasia on the basis of information given to them by doctors: information about their diagnosis, prognosis, treatments available and anticipated degree of future suffering. If a doctor confidently suggests a certain course of action, it can he very difficult for a patient to resist. However, it can be very diff icult to be certain in these areas. Diagnoses may be mistaken.7 Prognoses may be wildly misjudged. New treatments which the doctor is unaware of may have recently been developed or about to be developed. The doctor may not be up-to-date in symptom control.

Doctors are human and subject to temptation. Sometimes their own decision-making may be affected , consciously or unconsciously, by their degree of tiredness, or the way they feel about the patient. Voluntary euthanasia gives the medical practitioner power which can be too easily abused, and a level of responsibility he should not rightly be entitled to have. Voluntary euthanasia makes the doctor the most dangerous man in the state.

11 Leads inevitably to involuntary euthanasia.

WHEN VOLUNTARY euthanasia has been previously accepted and legalised, it has led inevitably to involuntary euthanasia, regardless of the intentions of the legislators. According to the Remmelink Report, commissioned by the Dutch Ministry of Justice, there were over 3,000 deaths from euthanasia in the Netherlands in 1990. More than 1,000 of these were riot voluntary'. Other assessments have been far less conservative, Summary and these figures pre-date February 1994, when euthanasia in that country' was effectively legalised.

Holland is moving rapidly down the slippery slope with the public conscience changing quickly to accept such action as acceptable. The Royal Dutch Medical Association (KNMG) and the Dutch Commission for the Acceptability of Life Terminating Action have recommended that the active termination of the lives suffering from dementia is morally acceptable under certain conditions. Two earlier reports of the Commission affirmed the acceptability of similar action for severely handicapped neonates and comatose patients. Case reports include a child killed for no other reason than it had abnormal genitalia, and a woman killed at her own request for reasons of mental suffering.

I have already alluded to the Nazi holocaust. Many are unaware that what ended in the 1940s in the gas chambers of Auschwitz, Belsen and Treblinka had far more humble beginnings in the 1930s: in nursing homes, geriatric institutions and psychiatric hospitals all over Germany. Leo Alexander, a psychiatrist who worked with the office of the Chief of Counsel for War Crimes at Nuremberg, described the process in the New England Medical! Journal in July 1949;
"The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the attitude, basic in the euthanasia movement that there is such a thing as a life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted,

the racially unwanted and finally all non Germans. Such a procession requires only four accelerating factors; fa vourable public opinion, a handful of willing doctors, economics pressure and a law allowing it."

In most western countries, the first three ingredients are present already. When legislation comes into effect, and the political and economic interests are brought to bear, the generated momentum can prove overwhelming. History has shown clearly that once voluntary euthanasia is legal involuntary euthanasia inevitably follows.

12 The British House of Lords recently recommended no change to the law on euthanasia after an extensive inquiry.

IN VIEW OF INCREASING public interest in euthanasia and in the light of the Nigel Cox and Tony Bland cases, the House of Lords set up a Select Committee on Medical Ethics to look seriously into this issue in 1993. During their deliberations they took submissions from a variety of persons and parties. Of these, the Department of Health, the Home Office, the British Medical Association and the Royal College of Nursing all argued against any change in the law The committee, in its final report in February 1994, despite being earlier undecided on the issue unanimously ruled that there should be no change in the law.

Lord Walton, the committee chairman reflected on this in a speech to the House of Lords on 9 May 1994 in saying:

"We concluded that it was virtually impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation of the law in the United Kingdom could not be abused. We were also concerned that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death."
While decisions made in the House of Lords are clearly not binding on other countries, such an extensive review and unambiguous decision does carry great weight. Others considering changes to the law would be well advised to examine the arguments which convinced it to come to the above conclusion.

WE NEED TO RECOGNISE that requests for voluntary euthanasia are extremely rare in situations where the physical, emotional and spiritual needs of terminally ill patients are properly met. As the symptoms which prompt the request for euthanasia can be almost always managed with therapies currently available, our highest priority must be to ensure that top quality terminal care is readily accessible.

While recognising the importance of individual patient autonomy, history has clearly demonstrated that legalised euthanasia poses serious risks to society as a whole. Patients can be coerced and exploited, the search for better therapies is compromised, and involuntary euthanasia inevitably follows.

Legislation allowing voluntary euthanasia should be firmly resisted on the grounds that it sidesteps true compassionate care (because effective alternatives exist) and ultimately undermines rather than protects patient autonomy.

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Peter J. Sanders is a fifth-generation New Zealander, Born in Christchurch in 1958, he was Dux of Lynfield College in Auckland. Dr Saunders is a graduate of the University of Auckland and the Royal Australian College of Surgeons. He is a former General Surgeon and medical missionary. He is the Student Secretary of the Christian Medical Fellowship in London, a group of over 4,000 British doctors. He is a lecturer and writer in the field of

medical ethics. Dr Saunders and his wife Kirsty (MHChB) live with their three sons in St Alban's, London.

Endnotes

1. Select Committee on Medical Ethics: Report, House of Lords paper 21 -1, London: HMSO 1994. 2. Twycross: 'A Doctor's Dilemma', Journal of Christian Medical Fellowship 39 (1993),1.153.
3. Ventafridda: 'Euthanasia: More Palliative Care is Needed' (letter), British Medical Journal 309 (1994),472.
4. Brandt: Nuremberg Trials, 1948.
5. International Code of Medical Ethics, adopted by the Third World Medical Assembly, London,
England.
6. Handbook of Declarations, Ferney-Voltaire: WMA 1992.
7. Rees at al: 'Patients with Terminal Cancer (who have neither terminal illness nor Gancer)', British Medical Journal 295 (1987), at pp.318-9.
8. Van der Maas at al; 'Euthanasia and Other Medical Decisions Concerning the End of Life', Lancet 338 (1991), at pp.669-74.
9. Hellema: 'Dutch Doctors Support Life Termination in Dementia;, British Medical Journal 306 (1993),1364.
10. 'Dutch Doctors Pushed on to "Slippery Slope" over Euthanasia;, The Independent, February 1 7,1993, p.8.
11. Shelton: 'Judges Make Historic Ruling on Euthanasia', British Medical Journal 309 (1994), at pp. 7-8.
12. Alexander: 'Medical Science under Dictatorship', New England Journal of Medicine 241 (1949), at pp. 39-47.
13. Select Committee on Medical Ethics, op. cit.