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

Dear Sir,
The Committee on Bioethics of the Uniting Church in Australia (Victorian Synod) wishes to make a submission to the Senate Standing Committee in relation to the private Senator's bill introduced by Senator Bob Brown. This bill proposes to repeal the Euthanasia Laws Act 1997 to allow the Northern Territory, the Australian Capital Territory and Norfolk Island to make legislation for people who are terminally ill.
The Uniting Church Bioethics Committee is opposed to any legislation allowing euthanasia, medically assisted suicide or physician assisted dying.

Definitions

Euthanasia is defined as intentional killing by a medical practitioner in order to relieve a patient's suffering.
Medically assisted suicide or physician-assisted dying is when a doctor provides the means for self killing to a person who has requested it.

While we can argue about euthanasia based on our faith relating to God, death and the human person, many who do not share these beliefs think that the church's position is irrelevant for them. Nevertheless, we have to correct factual misconceptions and argue from shared values.

1. For many years the main thrust for those advocating euthanasia has been that it is necessary to prevent people from dying in pain.
. Morgan Gallop polls since 1946 have asked the hypothetical question "If a **hopelessly** ill patient, in **great** pain, with absolutely **no** chance of recovery asks for a lethal dose, so as not to wake again, should a doctor be allowed to give a lethal dose or not?" The poll question was not "Do you think euthanasia should be legalised?" but "Would you favour dying in agony or euthanasia?" Naturally, many people chose euthanasia. Pain relief is not given as an option, as the hypothetical patient's pain **cannot** be relieved.
The great advances in pain management since 1946 make this scenario extremely unlikely in 2008, with new drugs and analgesic techniques being continually developed.
There have been opinion surveys asking "Should euthanasia be legalised?" but when these are self selected respondents of a newspaper poll the results may not reflect the opinions of the general population.

A common misconception relates to the "**doctrine of double effect**" i.e. "drugs administered for pain relief may be foreseen to shorten a patient's life, but nonetheless is not intended to do so". The "doctrine of double effect" became a public issue in 1957 when Lord Devlin gave advice to a jury, relying on medical opinion of the day, that morphine and heroin were dangerous, and their use for pain relief inevitably caused or contributed to death through respiratory depression.

However, it is now recognized that this "assumption concerning cause of death and the use of opioid and sedative drugs in palliative care is wrong. Any drug can endanger life if used inappropriately, but the knowledge and skills built up over some 30 years of palliative care practice have shown that opioids and other similar drugs can quite safely be used for symptom control without bringing causation into question if the parameters of accepted practice are followed. Pain is treated by opioid drugs without danger to life for weeks and often months before death, and for even longer in people with chronic pain who live a normal life span". (Ashby M, "Denying but not Defying". *Eureka Street*, June 2006).

This widely held belief that morphine shortens life can have unfortunate consequences.

- Patients who are prescribed morphine frequently think this means that they must be close to death.
- Many patients, believing pain killers will shorten their life, decide to put up with the pain. This results in unnecessary suffering.
- Not infrequently, dying patients, relatives or carers may believe that morphine is causing or contributing to the death and they or their relatives request or demand that the morphine be ceased, this resulting in avoidable pain.
- Doctors and nurses who have indicated in surveys that they had 'hastened death' may have believed they were responsible, if a patient died after receiving morphine, when actually the patient died of the disease while the morphine merely relieved the suffering.
- The "doctrine of double effect" may be regarded as a legal and ethical loophole from which to argue for euthanasia.

Of course a person **can** be killed by giving a large overdose of an opioid drug such as morphine. However there are several medications which can reverse the effect of an overdose. Morphine has a wide margin of safety.

On the other hand **unrelieved pain** may cause stress and may accelerate death. Pain **relief** can improve the quality of life, help a person to sleep better and move about more freely. Mobility may diminish complications such as pneumonia, bed sores and blood clots, all of which may hasten death.

2**. Advances in Palliative Care** Certainly some patients suffer greatly from problems other than pain. Symptoms such as vomiting, breathing difficulties, anxiety and depression are also treated. Some patients may have communication, relationship, spiritual or financial problems which may add to what is called the 'total' pain. Palliative care teams have access to doctors, nurses, pharmacists, social workers, chaplains, physio- and occupational therapists, dietitians and volunteers.

The illness may be a great burden to the patient's family and carers, and palliative care addresses their needs also. The pain of separation and loss cannot be avoided by either medicines or euthanasia, but palliative care may provide support and someone to share the grief.

3. The case for **autonomy** in dying is frequently expressed. e.g. "We strongly resent do-gooders placing obstacles in our way. Their activities are illegitimate interference with our liberty and autonomy in a matter most central to our life". (P. Shaw, "The Age"

31/1/07) also “It’s my life, not theirs, and they should have the courtesy to allow me to make the final BIG decisions while I am able”. (D. Flounders, “The Age” 30/1/07)
Euthanasia may provide a choice and control over the time or manner of dying. However sick and elderly patients are very vulnerable and subtle pressure from relatives to request euthanasia could be impossible to detect. They are already gently coerced in other areas affecting their care. Even now, many people are fearful of being an imposition or causing trouble for family and friends. Is the pressure of feeling one is a financial handicap, a worthless burden or ‘having passed one’s use-by date’ compatible with being an autonomous individual?
If euthanasia were an option, it would add to the distress and guilt of those who worried that they were **too great a burden** on others. At present they are protected by the fact that euthanasia is illegal, and it could cause tremendous stress if this protection were removed. **Allowing some people the right to choose, places an obligation on everyone to make a choice.**

4. There is a significant problem about just who would be euthanased or assisted in suicide. It has been stated “**With proper safeguards and protections in place**, the option should be there for you to die on your own terms” (B Jackson, Progress Leader, 6/2/07). The “proper safeguards and protections” are very problematic. Medical opinion is not totally infallible. There have been errors in prognosis and diagnosis.
Errors in Prognosis Prognosis or future life-span may be very difficult to estimate accurately. Some may live a normal active life for many years after their disease has spread, to the extent that it is incurable. There are well documented cases of spontaneous cure of widespread disease although these are exceptionally rare. However, as with capital punishment, if you get it wrong, it’s too late!

5. **Errors in Diagnosis** With modern technology, errors in diagnosis are rare, but still possible. Dr Jack Kevorkian (a retired American pathologist) was frequently in the news having assisted in over 100 deaths. Of the 69 who died between 1990 and 1998 and were investigated by an autopsy performed at the Oakland County District Office, Michigan, **only 25%** were found to have been terminally ill. Five patients had **no** anatomical disease at all. Also 71% were women; the divorced and never married were over represented. (New England Journal of Medicine 7/12/2000 page 1735).
In May, 2002 in Australia, Mrs. Nancy Crick was ‘helped to die’, with advice about suicide from Dr Philip Nitschke. She had been treated for cancer but believed she was continuing to suffer as a result of the cancer and was fearful of an inevitable increase of pain and suffering. No trace of cancer was found at her post mortem.

6. **Overseas experience**
There are significant dangers of legalizing euthanasia.
That there should be “adequate safeguards” to a euthanasia law is easier said than done. The British House of Lords Select Committee on euthanasia stated that it is impossible to set secure limits on voluntary euthanasia and “to create an exception to the general prohibition of intentional killing would inevitably open the way to its further erosion whether by design, by inadvertence or by the human tendency to test the limits of any regulation”. (Editorial. Their lordships on euthanasia. Lancet 343:19 Feb, 1994: 430-31)

The Netherlands This appears to have happened in the Netherlands. In 1991, although the patient was supposed to consent freely, there were 1000 cases of **involuntary** euthanasia. i.e. the life was terminated without the explicit request of the patient. (Van der Maas P J et al. Euthanasia & other medical decisions concerning the end of life. Lancet 338: 1991:669-674). In 410 of those cases, the patient was incompetent but the other 590 patients were competent. However, the decision was made by the doctor, with or without the relatives. (Pijnenborg L et al. Life-terminating acts without explicit request of patient. Lancet 1993:341:1196-99).
Euthanasia is not restricted to the final phase of life but can be considered whenever a patient's suffering appears hopeless and unbearable including psychic suffering of the physically healthy. (Stiefel F, Neue Zurcher Zeitung, 19 September 1994).
"The Age" reported 'the Amsterdam Court of Appeal dropped a murder charge yesterday against a doctor accused of killing a severely deformed new-born. This was the latest in a series of legal precedents slowly eroding the Netherlands' euthanasia limitations, and opening the door to euthanasia for those unable to ask for death, such as infants or the comatose'. (9 Nov 1995)
Despite the obligation to notify the Coroner an article from the Netherlands stated that 'a recent study among GPs discovered that 38 per cent of euthanasia cases were never reported. Generally, doctors are making their reports more acceptable than they are in reality, and in case of any complications or inadherence to the rules, the case is not reported'. (Zylicz Z The story behind the blank spot. Amer. J. Hosp. & Pall. Care, Jul-Aug 1993: 30-34) This has been called "the slippery slope"!

Switzerland Some Australians have travelled to Switzerland where euthanasia for non nationals is permitted. These were arranged by a lawyer, Ludwig Minelli and his organization "Dignitas". The nurse, Soraya Wernli, expressed her concerns to James Button, "the Age" correspondent in Zurich. She was alarmed at the haste of the process leading to suicide and the fact that not all clients had a terminal illness or an intolerable condition (as stated to be a requirement on the Dignitas website). Some were depressed and a few were merely old and wanted to die. Her husband, Kurt, also left although he had been a director of Dignitas and a friend of Ludwig Minelli for over 30 years. "I could not accept what he was doing. He was not interested in their (the clients') diagnosis, just their money". ("The Age" 3/2/07)
These cases illustrate the danger of allowing euthanasia and assisted suicide.

The Voluntary Euthanasia Society is now named "Dying with Dignity Victoria". Dignity is in the eye of the beholder. Why is death by suicide or euthanasia more dignified than death by natural causes, "when our time has come" with palliative care alleviating any symptoms if necessary and a person surrounded by those who love and care?
The British House of Lords again recently (2005) conducted an extensive enquiry and recommended there be no change to the law prohibiting euthanasia.
We certainly agree with "physician-assisted dying", when it involves medical skills to relieve pain and symptoms and promote constructive, compassionate care for the dying - but not by killing them.

(Nell Muirden, 8th April, 2008)

On behalf,
Committee on Bioethics,
Synod of Victoria
Uniting Church in Australia.