

Assisted dying laws pose a grave risk to the vulnerable

Joel Hodge September 7 2017

Fred is suffering from terminal cancer and has intense periods of pain. He is being looked after by a young carer, Greg. Fred has no relatives. Greg has been relatively good to Fred, so Fred leaves some money for Greg in his will.

Greg convinces Fred to see a doctor and consider his options. Fred is presented with the option of assisted suicide and is assessed by another doctor. Fred doesn't want to die but he also doesn't want to be a burden. Greg says the pills will give Fred control and the death he deserves. Greg helps Fred draft a written request.

They return to the doctor and Fred is assessed as a suitable candidate for the prescribed suicide medication. He has mixed feelings about whether to use the pills. Have euthanasia or physician-assisted suicide laws – of the kind that the Victorian Parliament is going to consider – worked in this case? Have the appropriate safeguards protected the elderly and dying person?

In the model proposed for Victoria, there are 68 safeguards, which are claimed to ensure the most rigorous euthanasia regime.

Yet, is it possible for a state to create safeguards to mediate a complex human situation like the one above, and avoid pressure, coercion and abuse?

In a study of states with euthanasia law, published in *Current Oncology*, Dr J. Pereira writes that "laws and safeguards are regularly ignored and transgressed in all the jurisdictions and that transgressions are not prosecuted. For example, about 900 people annually are administered lethal substances without having given explicit consent, and in one jurisdiction, almost 50 per cent of cases of euthanasia are not reported."

Pereira also found that in jurisdictions that legalised euthanasia, it soon changed from a last resort to a first choice option, with patients not being given the option of palliative care.

With euthanasia laws, much is invested in medical professionals to assess people and situations. But to communicate with and fully assess someone's health, motivations, and mental state in one or two appointments to enable a life-or-death decision is a difficult task.

Associate professor Mark Boughey, co-director of the Centre for Palliative Care, commented to *Health Matters* magazine that "therapeutic communication isn't a fundamental competency for healthcare professionals... there is a lack of suitably skilled people to work with end-of-life patient issues."

It is easy to underestimate the vulnerability of the elderly and dying, and the delicate human dynamic involved in caring for them. Whenever we are seriously ill, we are placed in a precarious position, heavily dependent on others and confronting all manner of fears.

Mark Boughey notes that "when patients are facing critical points in their illness trajectory, they start to express not only their own sense of anxiety about the likelihood of dying, but also their sense of burden".

Addressing this sense of anxiety and burden, as well as other mental health issues and support structures, requires a well-attuned and skilled care environment. The attitudes of the dying to death often fluctuate with different factors and circumstances.

Euthanasia will shift the dynamics of this environment by introducing a new possibility: the doctor's ability to facilitate death.

Some people will welcome this possibility as a way to increase their autonomy, especially with ongoing and intense pain and dependency.

On the other hand, many will fear it, because it will make them even more vulnerable, subject to the decisions and pressures of others. Thus, we have two competing concerns. Both are weighty concerns, but the priority of any new law should be to avoid causing any new harm to the innocent and vulnerable.

With troubling rates of elder abuse and inheritance squabbles, we should not be naive

about the context in which euthanasia will be used and the ability of safeguards to protect everyone.

In the *New Zealand Herald*, Simon O'Connor, the chairman of New Zealand's recent parliamentary commission into euthanasia (which did not recommend for or against euthanasia), warned:

"It is very difficult to see how there could be sufficient safeguards to actually protect vulnerable people in New Zealand. And that's been the experience overseas as well.

"It probably comes down to the simple question of 'how many errors would Parliament be willing to accept in this space?'"

There are just too many places where processes can go wrong: inadequate communication, lack of proper medical and psychological support (especially in rural or poorer areas), unintended or underlying pressure from relatives, carers, doctors or bureaucrats, explicit coercion, and criminal abuse.

The inadequacy of safeguards and the attendant risks for the dying suggest that euthanasia may actually undermine autonomy and place unexpected pressures on them.

Moreover, medical professionals report that the overwhelming majority of people in palliative care just want good care, not to have their death hastened. Euthanasia laws often create a disincentive to direct resources to palliative care.

The potential for legalised harm – whether intended or not – is the major danger from euthanasia laws. This poses a grave risk to the vulnerable.

<http://www.smh.com.au/comment/assisted-dying-laws-pose-a-grave-risk-to-the-vulnerable-20170904-gyaim0.html>