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EXECUTIVE SUMMARY

Re (Term of Ref 1) How current medical practices and palliative care can assist a person manage their end of life.

There are some evident problems in General Medicine which require attention to improve the ability of people to manage end-of-life care which include:

1.1 There is confusion about the goals of patient care (is it cure or palliation?) especially in hospitals, sometimes leading to inappropriate use of acute medical treatment (resuscitation) in some terminally ill patients, when usually what is required in terminally ill patients is the goal of symptom control only ie. Palliative care. This confusion of goals and mindless (mis) application of the wrong goal in hospital care sometimes promotes a fear of medical treatment, and is a factor in the attractiveness of assisted suicide.

1.2 There is poor understanding and application of Palliative care principles by many medical and nursing staff who do not work in formal Palliative care services

1.3 There is poor community understanding of Palliative Care treatment and distorted beliefs about terminal symptoms which can lead to elevated fears of medical care.

Initiatives which will improve care are:

1.4 Improved education of all medical and nursing staff as to the importance of clarification of the GOAL of care of all patients- ie cure of illness, OR palliative relief of symptoms.

The GOAL OF CARE should be determined by discussion with the patient, and family, and documented in all patient histories. This would help prevent the inappropriate and unwanted use of technology which a person may explicitly reject.

1.5 Better education of medical and nursing staff about the means of control of distressing terminal symptoms ie. better palliative care knowledge for all medical staff (not just bigger formal palliative care services).

1.6. *There is evidence Advance Care Directives improve end of life care, and patient and family satisfaction, and reduce stress, anxiety, and depression in surviving relatives.*

Advance care directives have some limitations.

Current acceptance and use of Advance Care Directives are limited.

There is a need for more public education about Advance Care Directives (ACD's), but also a refocus on wording. The point is not refusal of ALL treatment, BUT clarification of the GOAL of treatment (ie. cure OR symptom-control palliation); otherwise some people think they should refuse ALL treatment, and are then at risk of refusing useful palliative treatment.

Re (Term of Ref 2) How this issue is managed in other Australian and international jurisdictions

2.1 *Some advocate legislation for Assisted Suicide.*

But, the problems in end-of-life care are mainly clinical management and communication problems. There are major consequences of assisted suicide legislation. If it was accepted that doctors participate in taking the life of patients (even with narrow criteria) it would institute a major change to medical and social culture with many consequences.

2.2 *It is not possible to establish adequate safeguards to such legislation*

2.3 *The experience of assisted suicide and euthanasia in the Netherlands and Belgium show clearly that consequences of assisted suicide legislation are:*

- creeping extension of the criteria to include euthanasia without request,*
- euthanasia of non-terminally-ill people,*
- euthanasia of people with psychiatric illness eg. . non-terminally ill people with grief and suicidal thought from Depression have been euthanased.*

These consequences of assisted suicide legislation are both inevitable (as the Netherlands and Belgian experience shows) and unacceptable in a civilized society. There are case examples in the detailed submission.

2.4 *There is a risk of subtle coercion, with a serious risk of elder abuse*

2.5 *Most International Reports on assisted suicide and euthanasia have rejected the proposal because of the impossibility of adequate safeguards, and the consequences for the community.*

2.6 *Most major medical organisations (eg. The World Medical Association) are opposed to assisted suicide/euthanasia while advocating active palliative symptom control.*

Re (Term of Ref 3) Potential changes to our legislative framework.

3.1 No legislation is required to create 'certainty'; a doctor whose treatment is directed at purely symptom-control has nothing to fear. There may be a lack of understanding by some doctors of existing legal provisions.

3.2 The process of consideration of legislative change for assisted suicide must recognize that a law change affects ALL citizens.

Responsible legislators must consider all the (poorly recognised) consequences of Assisted Suicide legislation, taking into account evidence from Belgium and Netherlands of extension of euthanasia and assisted suicide to groups other than terminally ill people.

Debate about euthanasia and assisted suicide has, in the past, been focused on the individual and framed as a conflict between asserted autonomy and sanctity of life arguments. Autonomy of an individual cannot be absolute, because others in the community are affected by a law change.

But the key matter to understand is the ripple effect of detrimental consequences flowing from making the taking of life a type of medical treatment, changing the culture of illness management, and opening the door to the taking of life of any individual who is perceived as suffering, even without the use of available conventional treatment.

3.3 Assisted suicide legislation typically proposes 'adequate safeguards'.

Consideration of the practicality of process reveals:

- the impossibility of adequate safeguards (there will always be someone who will sign),
- the impossibility of excluding subtle coercion of seriously ill people,
- and the likelihood of elder abuse.

3.4 It is submitted that evidence from the Netherlands and Belgium leads to the conclusion that assisted suicide legislation is unsafe legislation because of the impossibility of adequate safeguards, the inevitability of widened criteria, and the likelihood of elder abuse and mistreatment of people with depressive illness especially.

3.5 Komesaroff and Charles have proposed in their article 'A minimalist legislative solution to the problem of euthanasia'. [in MJA 202(9). 18 May 2015]. As the authors state, there have been no prosecutions of Australian doctors, so by implication existing legislation is sufficient. Their proposal would in effect allow euthanasia and assisted suicide to be constrained only by a doctor's unverifiable belief. It would still allow crossing of the line such that medical staff would participate in the deliberate ending of life- a major change to the concept of medical treatment, with many consequences.

CONCLUSIONS OF THIS SUBMISSION

A) The main problems in clinical care are those of poor knowledge of palliative care and poor communication. There is no need for further legal protection of doctors whose behavior is directed at palliative symptom control.

The harms and obvious detrimental consequences of assisted-suicide legislation on the community tip the balance in favour of solutions which respect the common good. The risks of assisted suicide legislation are too great, because of the consequences, especially:

- safeguards are illusory
- extensions of the criteria to include euthanasia without request,
- euthanasia of non-terminally-ill people,
- euthanasia of people with psychiatric illness, especially depression.

Debate about euthanasia and assisted suicide has, in the past, been focused on the individual and framed as a conflict between asserted autonomy and sanctity of life arguments. Autonomy of an individual cannot be absolute, because others in the community are affected by a law change.

The key matter to understand about assisted suicide legislation is the ripple effect of detrimental consequences flowing from making the taking of life a type of medical treatment. This changes the culture of illness management, and opens the door to the taking of life of any individual who is perceived as suffering, even without the use of available conventional treatment.

B) Recommendations

Recommendation 1.

That knowledge about palliative care which is already available amongst specialized medical and nursing practitioners (but as yet inadequately used) is made more available. In other words there is a need for expansion of palliative care *principles* to general medicine. Better practice of palliative care in the general medical community would go a long way towards relieving current suffering.

Recommendation 2.

There is a need to make clarification of 'the goal of care' explicit in all medical care, especially all hospital admissions of seriously ill people, at the time of admission. Require medical staff to discuss and clarify the goal of care with the family of all hospital admitted patients, at the time of admission. This should become part of standard admission procedure.

Recommendation 3.

Better publication of information of Advance Care Directives to raise public awareness. Also a refocus on wording would be helpful: the point is not refusal of ALL treatment, BUT clarification of the GOAL of treatment (ie. cure OR symptom-control palliation), and the circumstances in which the ACD would apply.

DETAILED SUBMISSION

1. Re (Term of Ref 1) How current medical practices and palliative care can assist a person manage their end of life.

The evident clinical problems in end-of-life-care which require attention in order to improve the ability of people to manage end-of-life care include:

1.1 There is common confusion about the *goal* of patient care (is it cure or palliation?) especially in hospitals, which can lead to the use of acute medical treatment (resuscitation), when usually what is required in terminally ill patients is the goal of symptom control only ie.palliative care.

A recent article in the Medical Journal of Australia proposes this emphasis as much needed. [ref: Goals of care: a clinical framework for limitation of medical treatment Robyn L Thomas, Mohamed Y Zubair, Barbara Hayes and Michael A Ashby Med J Aust 2014; 201 (8): 452-455.]

1.2 There is a poor understanding and application of palliative care principles outside of formal Palliative care services. Many doctors, especially in hospital practice, seem to be unaware of this fundamental issue in terminal care. Hence many patients receive resuscitation when they deteriorate, instead of symptom control; this is often distressing to family members, and its mindless (mis) application in hospital care leads to a fear of all medical treatment.

[ref: Haines IE, Zalcborg J, Buchanan JD. Not-for-resuscitation orders in cancer patients — principles of decision making. Med J Aust 1990; 153: 225-229.]

1.3 Community ignorance about Palliative Care and symptom control leads to fear of terminal symptoms, and pessimism about palliation.

Incorrect beliefs about the frequency and levels of terminal symptoms, and of the benefits of Palliative Care treatment, sometimes leading to elevated fears of medical care.

[ref: Patients' beliefs about cancer management. Buchanan J, Borland R, Cosolo W, Millership R, Haines I, Zimet A, Zalcborg J Supportive Care in Cancer : Official Journal of the Multinational Association of Supportive Care in Cancer [1996, 4(2):1]

1.4 There is evidence Advance Care Directives (ACD's) improve end of life care and patient and family satisfaction and reduce stress, anxiety, and depression in surviving relatives. Current knowledge, acceptance and use of them is limited.

ACD's have some limitations, because the trajectory of patient deterioration cannot always be easily predicted.eg. a person may sign an ACD thinking of the circumstance of slowly progressive cancer in the future, but suddenly have a heart attack with rhythm disturbance which may be easily reversible, and could restore the person quickly back to their normal health; presumably they would want the ACD only to apply to slow inevitable decline, not sudden treatable illness.

ACD wording should be more specific, in order to be clear about the person's wishes in the case of serious irreversible illness, but also acute reversible illness.

[ref: Difficult but necessary conversations — the case for advance care planning.
Ian A Scott, Geoffrey K Mitchell, Elizabeth J Reymond and Michael P Daly Med J Aust 2013;
199 (10): 662-666.]

There is a need for more public education about ACD, but also a refocus on wording.
The point is not refusal of ALL treatment, BUT clarification of the GOAL of treatment,
otherwise some people are at risk of refusing useful palliative treatment.
Palliative care is not refusal of all treatment, but a refocus of the goal of treatment to
symptom-relief.

Re (Term of Ref 2) How this issue is managed in other Australian and international jurisdictions.

2.1 Some advocate Legislation for Assisted Suicide.

*Some Background information from the recent Scottish Parliament Report[ref: Extracts from
6th Report, 2015, Report on Assisted Suicide (Scotland) Bill
(www.scottish.parliament.uk)]*

The situation in The Netherlands

In the Netherlands, euthanasia and assisted suicide are both permitted under the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001.
Total deaths from euthanasia and assisted suicide in the Netherlands increased from 2331 in 2008, to 4188 in 2012.

The situation in Belgium

In Belgium, only euthanasia is lawful. It is permitted under the Euthanasia Act 2002.
Cases of euthanasia have increased from 24 reported cases in 2002, to 1807 reported cases in 2013, although *euthanasia is likely to be under-reported* given (i) *that there is no penalty for failing to report (recent research estimated that the reporting rate in 2007 was likely to be around 52.8%),* and (ii) *that professional guidance from the Belgian medical profession's governing body advises members not to enter euthanasia as a cause of death on death certificates.*

Euthanasia was initially restricted to patients over the age of 18 and minors over 15 who had been 'legally emancipated'. However, recently the law was extended to all ages, although children would require the approval of their parents and counselling by doctors and a psychologist/psychiatrist.

Oregon

In Oregon, physician-assisted suicide is lawful under the Death With Dignity Act 1994, but euthanasia remains unlawful. The only process permitted by the Act is the provision of a lethal prescription by a physician which must then be self-administered by the patient.
The only criteria in Oregon are that the patient must be aged over 18 and suffering from "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, produce death within six months". There is no additional requirement regarding intolerability, unbearable suffering, or the like.

Physicians must report each prescription written under the Act, as well as each death resulting from ingestion of the prescribed substance.

There is no penalty for not reporting a prescription or a death.

In 1998 there were 16 deaths under the Act; this rose to 71 deaths in 2013.

The basis for advocacy of assisted suicide is around issues to do with relief of suffering, personal autonomy, and fears. The theme of advocacy is often termed 'dying with dignity' – which assumes that assisted suicide is necessary to achieve that.

However, it should be noted that measures to bring about "a good death" in the majority of cases are already in place in terms of palliative care services and legislation, such as the Medical Treatment Act.

However palliative care is still under-utilized, and many healthcare professionals do not understand it or practise it properly- a factor in the existence of unnecessary suffering.

Some calls for legislative change come about because of poor palliative care, which although available, is often not utilized, and often because of a neglect of the emotional needs of distressed relatives.

Palliative care principles are underutilized outside of specialist palliative care services, and must be more widely promulgated.

The author developed a medical student teaching program at Austin/Repat Oncology some years ago. This sort of course needs replicating.

[ref: Medical education in palliative care. Buchanan J, Millership R, Zalcborg J, Milne J, Zimet A, Haines I. Med J Aust 1990, 152(1):27-29]

2.2 Proposals for Assisted Suicide are qualified by 'with adequate safeguards'.

But it is submitted that it is impossible to create adequate safeguards.

Recognition of the consequences of physician assisted suicide legislation start with the reality that, despite efforts to ensure adequate guidelines, no satisfactory safe guidelines are in fact possible. There will always be medical practitioners who for various reasons are willing to state that a person is "of sound mind", and that assisted suicide is 'justified'.

Importantly, a euthanasia request may be an indication of an unsolved symptom problem. What if palliative care measures have not actually been exercised properly, and hence suffering is unrelieved because best treatment has not actually been used?

What if the problem is that a relative is actually the one most distressed, not the actual patient, but there is pressure from others to end the patient's illness by assisted suicide?

[ref: Clinical issues in euthanasia Zalcborg JR; Buchanan JD :

The Medical Journal Of Australia [Med J Aust] 1997 Feb 3; Vol. 166 (3)]

2.3 The experience in the Netherlands and Belgium shows clearly that a consequence of assisted suicide legislation is extension of the criteria to include non-voluntary euthanasia, non-terminally-ill people, and people with psychiatric illness.

A *New England Journal of Medicine* study of Dutch end-of-life practices (ref: van der Heide et al 2007: 1960) found that, in 2005, "0.4% of all deaths [in the Netherlands] were the result of the use of lethal drugs *not at the explicit request of the patient.*")

The Rummelink Report 1991

On September 10, 1991, the results of the first, official government study of the practice of Dutch euthanasia were released. This report documents the prevalence of *involuntary* euthanasia in Holland, as well as the fact that, to a large degree, doctors have taken over end-of-life decision making regarding euthanasia. The data indicate that, despite long-standing court-approved euthanasia guidelines developed to protect patients, *abuse has become an accepted norm. The legislation has created a culture shift.*

According to the Rummelink Report, in 1990: 2,300 people died as the result of doctors killing them upon request (active, voluntary euthanasia). 400 people died as a result of doctors providing them with the means to kill themselves (physician-assisted suicide). 1,040 people (an average of 3 per day) died from involuntary euthanasia, meaning that doctors actively killed these patients *without the patients' knowledge or consent.*

14% of these patients were fully competent, 72% had never given any indication that they would want their lives terminated, In 8% of the cases, doctors performed involuntary euthanasia despite the fact that they believed alternative options were still possible.

In addition, 8,100 patients died as a result of doctors deliberately giving them overdoses of pain medication, not for the primary purpose of controlling pain, but to hasten the patient's death. In 61% of these cases (4,941 patients), the intentional overdose was given *without the patient's consent.*

According to the Rummelink Report, Dutch physicians deliberately and intentionally ended the lives of 11,840 people by lethal overdoses or injections—a figure which accounts for 9.1% of the annual overall death rate of 130,000 per year. The majority of all euthanasia deaths in Holland are *involuntary deaths.*

In the Netherlands and Belgium the criteria have crept to non-terminally ill people, and those with psychiatric illness, especially depression

[ref: Chambaere et al. CMAJ May 17, 2010 . In a 2007 study, 32% of euthanasia deaths that occurred in the Flanders region of Belgium were found to have occurred without explicit request or consent.

CASE EXAMPLES

Prof Tom Mortier's mother and Euthanasia for Depression.

A chemistry professor, Tom Mortimer, has challenged the Belgian euthanasia law, when his mother was euthanased because she was depressed in 2012 (she was not terminally ill. He only found out about his mother's euthanasia death after she died.

He is now suing the Belgian government.

This case was recently described in an article in the New Yorker.

[ref: New Yorker; Letter from Belgium | June 22, 2015

Title: 'The Death Treatment']

Calls for Euthanasia for Depression

In the Journal of Medical Ethics, recently two influential bioethicists have argued that euthanasia for patients suffering from ‘treatment-resistant’ depression should be allowed. Udo Schuklenk, of Queens University in Canada, and Suzanne van de Vathorst, of the University of Amsterdam, claim it is discriminatory to allow euthanasia or assisted suicide for terminally ill patients, but to deny it to those who suffer from ‘incurable mental illness’. There have been cases reported of non-terminally ill people being euthanased for complicated grief reactions and depression, with suicidal thought.

Eg. a woman whose husband and son had died; deaf twins, one of whom died and the other requested euthanasia

Dr Philip Nitschke.

Philip Nitschke, an advocate for assisted suicide, is explicitly clear in his wish to extend assisted suicide to all; he argues that anyone – including non-terminally ill people, and those with depression – should have the right to assistance to kill themselves.

Bureaucrats.

I have personally experienced medical workshops where hospital bureaucrats have asserted that assisted suicide legislation would enable them to empty some of their hospital and nursing home beds in a more expeditious manner.

Professor Theo Boer- a euthanasia advocate who changed his mind.

Prof. Theo Boer is a Dutch medical ethicist who has changed his mind on euthanasia. He wrote in the UK daily Mail “Pressure from relatives, in combination with a patient’s concern for the wellbeing of his beloved, is in some cases an important factor behind a euthanasia request. *I used to be a supporter of legislation. But now, with 12 years of experience, I take a different view.*”

Dutch extension to children

It should be noted that Dutch paediatricians are now backing euthanasia for children aged from 1 to 12. In a [position paper released on June 19](#), the NVK (the Dutch Paediatricians’ Association) recommended that deliberate termination of life be available when palliative care is ineffective.

“We feel that an arbitrary age limit such as 12 should be changed,” said Professor Eduard Verhagen, of Groningen University, a long-time champion of euthanasia for children.

“Each child’s ability to ask to die should be evaluated on a case-by-case basis.”

Belgium has already removed the age limit on euthanasia.

There is evidence of under-reporting in Belgium.

[ref: Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases. BMJ, Oct 5, 2010.

Comment: the study found that 47.2% of all euthanasia deaths were not reported.]

2.4 The risk of subtle coercion, and elder abuse.

The attitudes of family and professional practitioners are crucial in the management of seriously ill people. If the message is conveyed by attitude, that “ your life is not worth living”, ill people pick up on it very quickly. I myself, despite years of professional practice,

have experienced the common ambivalence towards a seriously ill relative. Part of you wants the person to live, but a part of you wants the whole thing over and done with.

How would it then be possible to ensure that relatives, or even nursing or medical staff, are not coercing ill patients into "requesting" assisted suicide, by their attitudes and expectations, especially if they are difficult, or there is a history of family conflict. What if such people were to benefit financially from the patient's death? What if some family members are against such a solution, and others are for it? What legal actions might follow family allegations that their relative was pushed into it?

A recent [Scottish parliamentary committee](#) examining a bill to legalize assisted suicide stated "There is no way to guarantee the absence of coercion in the context of assisted suicide." Assisted suicide and euthanasia are likely to result in cultural change in medical practice with many people, especially vulnerable and older people perceiving a 'duty to die'; this would be a form of elder abuse.

Few medical practitioners are properly trained to assess the subtleties involved with patients who may present asking for assisted suicide. These subtleties include individual misguided health beliefs, reluctance to use analgesia (often because of unrealistic fears about addiction), fear of palliative care, and experience of subtle coercion.

Psychiatric assessment in this context is not just a matter of whether a Major Depressive illness is present. A person may feel coerced, and that they are a nuisance to family and the community, and have quite distorted fears about an illness, but appear superficially to be of "sound mind".

[ref: Legalised euthanasia will violate the rights of vulnerable patients

BMJ. 2005 Sep 24; 331(7518): 684–685.

R J D George, senior lecturer, G Finlay, and David Jeffrey, chair of ethics committee]

2.5 Most International Reports on assisted suicide have rejected assisted suicide and voluntary euthanasia proposals because of the consequences for the community and the impossibility of adequate safeguards.

2.5.1 World Medical Association Resolutions --

on Euthanasia : "Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness."

on Physician-Assisted Suicide states: "Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient." (ref: adopted by the 44th World Medical Assembly, Marbella, Spain, September 1992 and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005)

2.5.2 Australian Medical Association National statement 2014

1 The AMA believes that while medical practitioners have an ethical obligation to preserve life, death should be allowed to occur with dignity and comfort when death is inevitable and when treatment that might prolong life will not offer a reasonable hope of benefit or will impose an unacceptable burden on the patient.

2 Medical practitioners are not obliged to give, nor patients to accept, futile or burdensome treatments or those treatments that will not offer a reasonable hope of benefit or enhance quality of life.

3 All patients have a right to receive relief from pain and suffering, even where that may shorten their life.

4 While for most patients in the terminal stage of an illness, pain and other causes of suffering can be alleviated, there are some instances when satisfactory relief of suffering cannot be achieved.

5 The AMA recognizes that there are divergent views regarding euthanasia and physician- assisted suicide. The AMA believes that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of futile treatment.

6 Patient requests for euthanasia or physician-assisted suicide should be fully explored by the medical practitioner in order to determine the basis for such a request. Such requests may be associated with conditions such as a depressive or other mental disorder, dementia, reduced decision-making capacity, and/or poorly controlled clinical symptoms such as pain. Understanding and addressing the reasons for such a request will allow the medical practitioner to adjust the patient's clinical management accordingly or seek specialist assistance.

7 If a medical practitioner acts in accordance with good medical practice, the following forms of management at the end of life do not constitute euthanasia or physician assisted suicide: not initiating life-prolonging measures; not continuing life-prolonging measures; the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.

8 Medical practitioners are advised to act within the law to help their patients achieve a dignified and comfortable death.

(ref: Position Statement on the Role of the Medical Practitioner in End of Life Care 2007 , amended 2014)

2.5.3 British Medical Association

- opposes all forms of assisted dying; supports the current legal framework, which allows compassionate and ethical care for the dying and; supports the establishment of a comprehensive, high quality palliative care service available to all, to enable patients to die with dignity (ref: Current BMA policy 2015)

2.5.4 The Scottish Parliament recently rejected an Assisted suicide Bill.

[ref: Extracts from 6th Report, 2015 (Session 4)

Stage 1 Report on Assisted Suicide (Scotland) Bill

www.scottish.parliament.uk]

Relevant extracts (the numbering is that of the Report)

re 'autonomy'

89. The Committee acknowledges that the principle of respect for autonomy is a qualified

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principle which is usually limited by the rights of others, by public safety considerations, and by the need to consider other principles and values.

92. Therefore, the Committee is not persuaded that the principle of respect for autonomy on its own requires the legalization of assisted suicide.

Re Coercion

194. the Committee notes the observation by the BMA that there is no way to guarantee the absence of coercion in the context of assisted suicide.

Re policy on suicide prevention

278. There appears to be a contradiction between a policy objective of preventing suicide, on the one hand, and on the other, legislation which would provide for some suicides to be assisted and facilitated.

280. The Committee is concerned that this has the potential not only to undermine the general suicide prevention message by softening cultural perceptions of suicide at the perimeters, but also to communicate an offensive message to certain members of our community (many of whom may be particularly vulnerable) that society would regard it as 'reasonable', rather than tragic, if they wished to end their lives.

292. The Committee is not persuaded by the argument that the lack of certainty in the existing law on assisted suicide makes it desirable to legislate to permit assisted suicide; it considers that the law must continue to provide an effective deterrent against abuse, and to be responsive to the individual facts of particular cases. [Paragraph 52]

295. Given the qualified nature of the principle of respect for autonomy, and the need to weigh it against other relevant legal and ethical principles, the Committee is not persuaded that the principle of respect for autonomy on its own requires that assisted suicide be permitted in some circumstances. [Paragraph 89-92]

Re (Term of Ref 3) Potential changes to our legislative framework.

3.1 No legislation is required to create 'certainty'; a doctor whose treatment is directed at purely symptom-control has nothing to fear.

3.2 *The process of consideration of legislative change for assisted suicide must recognize that a law change affects ALL citizens, and must include consideration of its effect on the whole community.*

Responsible legislators must consider all the (possibly unintended) consequences of Assisted Suicide legislation, taking into account the Belgian and Netherlands evidence of euthanasia and assisted suicide to groups other than terminally ill people.

Matters of individual autonomy are not the only issues which must be considered in examining the merits of such a law change. There are also the issues of the common good for the community, and how such legislation would affect other ill people, those with psychiatric illness or disability, and the practice of medicine in the community, aged care facilities and in hospitals.

Debate about euthanasia and assisted suicide has, in the past, been focused around a conflict between asserted autonomy and sanctity of life arguments.

But the key matter to understand is the ripple of detrimental consequences flowing from making the taking of life a type of medical treatment, changing the culture of medical treatment. In my view, we should have the foresight and wisdom to see where that leads.

3.3 Assisted suicide legislation typically proposes 'adequate safeguards' Consideration of the practicality of process and the clinical issues of communication reveals:

- a) it is not possible to establish adequate safeguards, and
- b) it is clear from the experience in the Netherlands and Belgium, that once the line is crossed, there is extension of the criteria (often argued on the basis of discrimination)
- c) there is a risk of coercion and a serious risk of elder abuse

Polls about euthanasia and assisted suicide can be misleading because of how the question is framed, and because many will not have an understanding of current practices in the Netherlands and Belgium, which illustrate the problems with such legislation

3.4 It is submitted that evidence from the Netherlands and Belgium leads to the conclusion that assisted suicide legislation is unsafe legislation for the community because of the impossibility of adequate safeguards, the inevitability of widened criteria, and the likelihood of elder abuse and mistreatment of people with depressive illness especially.

3.5 Komesaroff and Charles have proposed 'A minimalist legislative solution to the problem of euthanasia. [MJA 202(9). 18 May 2015]

As the authors state, there have been no prosecutions of Australian doctors, so by implication existing legislation is sufficient. Their proposal is of a defence 'that the doctor thought it was necessary to relieve the pain or suffering' .

*This would in effect allow euthanasia and assisted suicide constrained only by a doctor's unverifiable belief. It would still allow crossing of the line such that doctors would be involved with the deliberate ending of life, **so making the taking of life a part of medical treatment. Doctors should not be given such wide licence.***

Once it becomes accepted that doctors participate in taking the life of patients (even with narrow criteria) it institutes a change to medical and social culture with inevitable ripple consequences to other patients, especially the vulnerable.

CONCLUSIONS OF THIS SUBMISSION

A) The main problems in clinical care are those of poor knowledge of palliative care and poor communication. There is no need for further legal protection of doctors whose behavior is directed at palliative symptom control.

Law change is a poor and blunt way of improving clinical care.

The harms and obvious detrimental consequences of assisted-suicide legislation on the community tip the balance in favour of solutions which respect the common good.

The risks of Assisted Suicide legislation are too great, because of the consequences which flow on to affect others in the community.

The key matter to understand is the ripple of detrimental consequences flowing from making the taking of life a type of medical treatment, changing the whole culture of medical care, to the detriment of future patients. In my view, we should have the foresight and wisdom to see where that leads.

However an obligation follows to improve standard palliative care in ordinary medical practice.

B) Recommendations

Recommendation 1.

*That knowledge about palliative care which is already available amongst specialized medical and nursing practitioners (but as yet inadequately used) is made more available. In other words there is a need for expansion of palliative care *principles* to general medicine.*

Better practice of palliative care in the general medical community would go a long way towards relieving current suffering.

Recommendation 2.

There is a need to make clarification of 'the goal of care' explicit in all medical care, especially all hospital admissions of seriously ill people, at the time of admission

Require medical staff to discuss and clarify the goal of care with the family of all hospital admitted patients, at the time of admission.

This should become part of standard admission procedure.

Recommendation 3.

Better publication of information of Advance Care Directives to raise public awareness.

ACD wording should be more specific, in order to be clear about the person's wishes in the case of serious irreversible illness, but also acute reversible illness.