

Good palliative care would avoid social experiment of euthanasia



Premier Daniel Andrews declared Victoria's euthanasia law will be the "most conservative" in the world.

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Save



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The socially experimental state of Victoria, after a flawed process, proposes its gravest experiment — to allow doctors to terminate the lives of patients, thereby creating in law two classes of human beings, those whose lives should be preserved and those “better off dead”.

The line between these two categories, contrary to claims of Victoria’s euthanasia advocates, is highly arbitrary. Common sense, political reality and international experience testifies to the truth — once killing and assisted suicide is authorised according to certain rules the momentum to expand those rules becomes relentless, leading to increased numbers being terminated.

Reflect for a moment and ask yourself: do you actually doubt this would happen? The Voluntary Assisted Dying Bill introduced into the Victorian parliament by Health Minister Jill Hennessy is shot full of holes. In a sense this is not the fault of euthanasia’s advocates.

The real problem lies in the utopianism of the project and the impossible goals it purports to achieve. We are expected to believe the law can authorise killing and assisted suicide in the name of compassion yet at the same time somehow protect the vulnerable, the depressed, the poor and those anxious to “do the right thing by their family” from unnecessarily nominating themselves for the final poison.

The key to the politics of euthanasia lies in accepting that individuals should have this right yet pretending it will not transform the ethics of society as the culture of killing permeates into family, health and medical life. Most households, sooner or later, will take decisions, one way or another, cognisant of such a law. The dream of euthanasia without social damage is just that — a dream, seductive yet false.

The Victorian public has not been told the truth by pro-euthanasia politicians and this is one of the main themes of this article. Australian Medical Association president Michael Gannon, speaking from Chicago, tells *Inquirer*: “Once you legislate this you cross the Rubicon. Our position is we need to do better with end-of-life care and we say that doctors should have no role in intentionally ending a patient’s life. The medical profession is concerned because we will be expected to be involved.”

He says the AMA is a group of individuals with varying views, but of the 109 national medical associations representing different countries, 107 oppose euthanasia. “We greatly fear there will be coercion,” he says. “It is frankly commonplace for patients to tell doctors in the presence of their loved ones that they feel they are a burden on their families.”

Gannon identifies the core dilemma — emotion versus reason. He says: “The cause for euthanasia has been made in a very emotional way and this is the latest expression of individual autonomy as an underlying principle. But the sick, the elderly, the disabled, the chronically ill and the dying must never be made to feel they are a burden. They reflect a diversity in our society that is every bit as important as the LGBTI community.”

In a recent article for the *Huffington Post*, Gannon says: “Euthanasia/physician-assisted suicide makes us a poorer society not a richer one. While not all our members agree, the AMA opposes any interventions that have as their primary intention the ending of a person’s life.”

Euthanasia constitutes an immense failure of public policy. Gannon says this step “would in no way enhance the provision of quality end-of-life care”.

The further truth is that in Victoria (and Australia) politicians have declined to properly fund and provide adequate palliative care.

In its submission last week on the defects of the bill, Palliative Care Victoria said an estimated 10,000 Victorian died every year — one in four deaths — without access to needed palliative care. Is it any wonder people look to euthanasia? On what ethical basis do politicians, having failed to provide adequate medical care for the sick and elderly, now say real choice must involve euthanasia?

Palliative Care issued a grave warning: “The bill fails to provide mechanisms that will proactively and adequately monitor the safety of vulnerable persons which should be a high priority given the systemic issues and concerns.”

What values and principles guide this Labor government and its ideological obsessions? Palliative Care fears the spirit, not letter of the law, will be followed, with deaths being hastened as they have in jurisdictions such as Belgium. It expresses concerns about the impact on “the culture, practice and experience of healthcare” in Victoria. It warns the new law would threaten trust between patients and health practitioners

Referring to our “suicide contagion” with an estimated 65,300 Australians attempting to commit suicide in 2015 ((3027 succeeded), Palliative Care says: “Legalising voluntary assisted dying sends the wrong message to people contemplating suicide and undermines suicide prevention efforts.” It points to evidence: legalising voluntary assisted suicide is tied to an increased rate of total suicides (hardly a surprise) and does not result in any fall in non-assisted suicides (again, hardly a surprise).

Palliative Care Victoria warns this bill will operate with high risks for the sick and vulnerable, the point put by Gannon. Looking beyond Victoria, he says in other nations “the legislation has been changed so it can be used against vulnerable groups”. In The Netherlands these debased laws extend to involve children.

In The Netherlands last year, sanctioned killings and assisted suicide accounted for about 6000 deaths or one in 25 of deaths from all causes. The initial law in 1984 was introduced with the usual pledges that euthanasia without request would not occur, yet a series of official Dutch surveys disclose that physicians “have, with virtual impunity, failed to report thousands of cases and have given lethal injections to thousands of patients without request”.

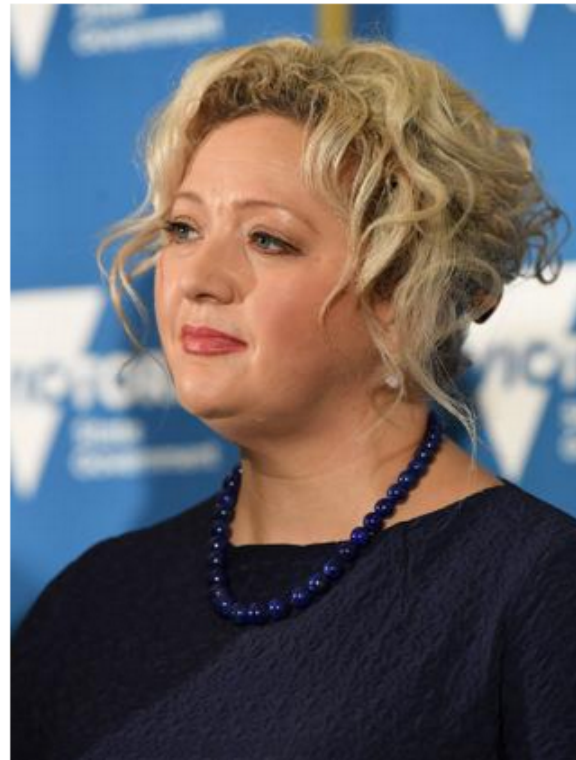
This analysis comes from John Keown, the Rose Kennedy professor at the Kennedy Institute of Ethics at Georgetown University, whose 54-page critique of the Victorian proposals will be published in the *Journal of Law and Medicine*. Keown says the feature of Victoria’s debate is the failure to make the ethical case for legislation given this issue is probably the most important in contemporary bioethics.

Keown says the language used by Victorian advocates is designed to conceal — the issue is whether the law should permit physicians to kill patients or assist patients to kill themselves. Euphemisms will not suffice. But what does it reveal when advocates cannot even use direct and honest language to describe what they advocate?

The most substantive document justifying legislation is last year's Victorian parliamentary committee report on end-of-life choices. In reply to the justifications it offered there are relevant rebuttals from Keown and others.

First, allowing euthanasia and assisted suicide repudiates a pivotal principle of criminal law and medical ethics that all humans, young or old, sick or well, suffering or not, possess a human dignity that cannot be swept aside. The effect of so doing creates under law two classes of people: those whose lives are worth living and those "better off dead".

As Keown says, going to the "inviolability" of human life, the principle is that regardless of age, health, gender, race, religion or sexual orientation there is an "intrinsic and equal worth" in humans such that sanctioning of killing and assisted suicide is a threshold that should not be crossed.



Victorian Health Minister Jill Hennessy.

Second, it is claimed that euthanasia is about patient choice and personal autonomy. Indeed, this seems the philosophical essence of the bill as explained by Premier Daniel Andrews and Hennessy — yet it is manifestly false. The proposed law, by definition, is discriminatory and arbitrary: it gives certain people on certain conditions access to euthanasia and denies it to others.

You need to be at least 18 years old; you need to have a disease or illness that will cause death within 12 months; you need to be suffering without a recourse the patient finds to be tolerable; you need to be able to make a request. What about somebody who is 17? What about somebody who suffers intolerable pain but isn't going to die within the year? Or who is suffering but not mentally able to make a request? What about their autonomy and choices?

At this point the nature of the project becomes apparent — the politicians are deciding on the arbitrary point that separates a life to be preserved from a life no longer worth living. But arbitrary dividing lines will be subject to constant pressure for change given the underlying principle is individual autonomy and choice. How could this not happen?

As Keown says, the Dutch and Belgians realised that once you establish the core principle then your moral argument to restrict the law cannot be sustained or limited just to those at “the end of life”. Leading advocates of euthanasia in the US and Britain “openly admitted that their proposals are merely a first step”. A push to extend the 2016 Canadian law is now under way in the courts.

Keown warns Victorian legislators, once they cross the Rubicon, will face demands from “right to die” groups briefing their lawyers to invoke the Victorian charter of rights to “open the door ever wider”. What will be their argument? That’s easy — it will be about “equality” and “freedom from discrimination” to access the relief provided by euthanasia that others are enjoying.

“Once the law is relaxed the principled arguments for its extension prove unanswerable,” Keown says. He says in 1996 Dutch courts — 12 years after deciding voluntary euthanasia was lawful to relieve suffering — decided non-voluntary euthanasia was lawful for the same reason. An increasing number of patients seek death for dementia, chronic illness and age-related complaints.

Newly appointed US Supreme Court justice Neil Gorsuch says when the costs associated with an activity are reduced — like removing the illegality of euthanasia and assisted suicide — there will be a growing demand. Keown offers more evidence — “the popular campaign in The Netherlands” to extend the law to allow those with “completed lives” to be assisted in suicide has been accomplished.

At a time when the community is plagued with issues around family violence, psychological illness and family financial pressures the embrace of euthanasia will compound individual tragedy. Think of the impact on an ailing mother of a son-in-law saying: “Mum, have you had enough, your daughter is very distressed?”

This leads directly to the third objection — effective legal control of euthanasia and assisted suicide is impossible as a practical challenge. Victorian advocates know this is a huge problem for their project that must be countered at all costs. Hence it drives their efforts to restrict eligibility and sees Andrews declare Victoria’s law will be the “most conservative” in the world — ironic given he thinks being conservative about legalising killing is something to boast about.

The minister says the Victorian bill applies only when a patient is diagnosed with “an incurable disease, illness or medical condition that is advanced, progressive and will cause death” within 12 months. The medical director at Marie Curie says predicting the time of death is “like predicting the weather”. Is a condition “incurable” if a patient refuses a cure? Accuracy dealing with death over a 12-month range creates wide scope and is difficult to get right.

The patient needs to obtain the support of two doctors who certify the criteria have been met. Keown asks: how will the doctors know the patient’s request is truly free and informed? There are many problems — no firm restriction on doctor shopping, no requirement the doctor be familiar with the patient, no guarantees patients are told about palliative care options, little regard for depression or mental illness that may drive a request and a test of “suffering” that is completely subjective.

Once the legal drug is provided to the patient the patient is on their own. Keown asks: if a physician is not present when the patient takes the lethal substance, how is the physician to know whether the patient was making a free decision when they swallowed it (or whether it was poured down the patient's throat by a relative or volunteer from a euthanasia pressure group)?

Keown says: "Effective control is not feasible. Real, practical problems, not least those of precise definition and proper enforcement are intractable, as the evidence from those few jurisdictions which have taken the radical step of relaxing their laws has amply confirmed."

Fourth, an argument for the bill is that some people are committing suicide in dreadful ways, many dying alone or in pain. The immediate question is obvious: how many could have been diverted from suicide by psychiatric, psychosocial and palliative support? Why aren't the depressed being treated for depression? Why aren't people being offered less lethal options than death?

The option of killing is disproportionate yet perhaps seductive given the dilemma caused by patient pain that needs money, care and substantially better policy. This raises the most serious ethical questions about the motives for euthanasia.

In its submission Palliative Care Victoria says recurrent funding over the three years 2014-17 has "only been sufficient to maintain the status quo" and has "not met the growing demand". With 46,000 Victorians in residential aged-care facilities, only 12 per cent received palliative care — while 30 per cent die each year. This is a "high risk" environment in relation to voluntary assisted dying. Yet effective policy is "considerably less well developed than for family violence and child abuse." Palliative Care says the bill "would provide for and regulate access to voluntary assisted dying" yet there is no parallel pledge to "provide for and regulate access to palliative care".

The constant political mantra about choice is extraordinary hypocrisy — de facto refusal to provide palliative care is the single greatest action in denying genuine choice. Palliative Care strongly dissents from the bill's 12-month "death expectation" provision because it "places many more people at risk of opting to proceed" who may have changed their mind based on new treatment, remission or misdiagnosis. It warns about the "lack of adequate assessment" of mental health on a patient's decision for euthanasia.

Fifth, another argument for the bill is that there is illegal practice by doctors anyway in helping patients die and the existing law is extremely difficult to enforce. "The fact that the criminal law treats cases of assisted suicide with leniency and compassion is not a matter for criticism but for credit," Keown says. The application of such discretion does not contradict upholding the existing law against euthanasia.

The final reflection is that this issue is the ultimate in the rising politics of compassion. Gannon says: "The community seems to be quickly swayed by stories of bad deaths. We have seen testimonials to this. The case of euthanasia has been made in a very emotional way by celebrities."

If grandpa decides to end his life, what impact does this have on the grandkids? Let's not pretend it has no impact because this is how social culture evolves. A mature society needs to distinguish between compassion and outcomes. Compassion is a virtue but compassion cannot become the sole basis for deciding public policy.

This is not about the plight of any particular person and how they may prefer to die. It is about the total ethical and compassionate framework for society. The warnings on the table could hardly be more serious. This is about what sort of civilisation we become and what damage we perpetrate in the name of love.

