

HEAD: Palliative care and physician assisted suicide: a sound medical view

BLURB: A group of palliative care physicians responds to Professor Emeritus Ian Maddocks ...

[IN his opinion piece in *MJA InSight*](#), Professor Emeritus Ian Maddocks proposes an integration of palliative care, euthanasia, and physician assisted suicide (EPAS). As palliative care practitioners, we know this supposed common ground is both a contradiction in terms and contrary to sound medical practice.

From our experience of caring for people who are ill and vulnerable, legalising EPAS is unnecessary and unsafe.

Despite its inevitability, dying is not a popular topic for discussion in Australia today. In the [words of American surgeon Dr Atul Gawande](#), we have “forgotten that we are mortal”. Death is not a medical or pharmacological event. It remains instead a profound mystery and the natural end of the complex journey of life. It is universal yet unique, personal but communal. It affects us all.

Dying can be traumatic, terrifying and painful for the patient, and challenging for the grieving family. In the face of inevitable death, some patients are willing to explore improbable alternative therapies, or burdensome or experimental treatments that may have a very low success rate. If people insist that “everything be done”, they are likely to die in the medically confronting environment of an intensive care unit, possibly prolonging the process of dying itself.

Good palliative care helps patients and families avoid both overtreatment and neglect of treatment. It enhances patient autonomy and decision-making capacity by improving symptom control and empowering patients to participate in their care. We affirm the patient’s right to choose their therapy; decline futile therapy; choose the place of dying; choose who should be present; receive the best possible relief of symptoms, even, on rare occasions, deliberate palliative sedation (not terminal sedation); and refuse to prolong the dying process. Ideally, this should be readily available for all those with life-limiting illness.

Autonomy does not include the right to demand that a clinician kills the person. Contrary to public opinion, [the use of therapeutic doses of analgesia or sedation in order to relieve difficult and intractable discomfort does not hasten death](#) and is not a form of euthanasia. Appropriate end of life prescribing of analgesia is simply good clinical practice when the patient is actively dying.

Supporting people when they are dying is utterly different to intentionally causing them to die. What Professor Maddocks calls “a single effective intervention” is in fact an act of killing.

The term “voluntary assisted dying” conceals the true nature of what is proposed in the bill before the Victorian parliament. The patient’s dying is not assisted; rather, a doctor is required to kill the patient or to help the patient commit suicide. The word “voluntary” attempts to emphasise the patient’s autonomy. Ironically, EPAS legislation weakens patient autonomy by devaluing the final stages of life. Further, [overseas experience has shown that supposed safeguards within these laws do not](#)

[effectively guard the autonomy of those most vulnerable to the extension of these laws.](#)

In an attempt to make EPAS publicly acceptable, its proponents sanitise the language, using euphemisms such as “voluntary-assisted dying” and “go gentle”. However, the inconvenient truth remains that at the heart of EPAS, the action of the doctor is to end a patient’s life or assist patients to kill themselves. This has profound ramifications for all health professionals. “Do not kill” has been a core ethical principle of every civilisation and the practice of medicine; we violate it at society’s peril.

Quality health care manages the causes of patients’ distress rather than ending life. In our experience, requests to terminate life prematurely are uncommon and often a cry for help. [Such requests rarely spring from uncontrolled pain, but rather from despair, a sense of loss of control, or fear of being a burden to others.](#) Evidence shows that [a person’s desire for hastened death changes over time and reduces when care is good.](#) It is illogical and immoral to even consider euthanasia legislation before ensuring there is universal access to palliative care.

The 1990 World Health Organization definition states that palliative care [affirms living and dying as a normal process, and “neither hastens nor defers death”.](#) Likewise, after extensive research and consultation, the Australian and New Zealand Society for Palliative Medicine (ANZSPM) [issued a position statement on EPAS in 2013.](#)

This statement affirmed that:

- the discipline of palliative medicine does not include the practice of EPAS; and
- ANZSPM opposes the legalisation of EPAS.

In the Netherlands, often quoted as a euthanasia success story, so many doctors have refused to kill their patients that [the government has established mobile euthanasia teams to perform EPAS across the country.](#) [Doctors in Canada are increasingly requesting to be removed from “assisted dying” lists.](#) The legalisation of EPAS results in great harm to vulnerable individuals, families, the community and [health professionals.](#)

Paradoxically, it is in dying naturally that many people find healing and realise what is truly important in their lives. They may experience profound personal growth and family reconciliation. Indeed, as Canadian surgeon, Professor Balfour Mount, who coined the term “palliative care” wrote: [“It is possible to die healed”.](#)

We write as an informal network of Australian and New Zealand practitioners in palliative care. We do not represent any particular organisation, institution or philosophy. Some of us have practised palliative medicine for more than 30 years. We acknowledge that death, like birth, can be distressing and messy. We are deeply concerned at the increasingly determined attempts to legalise the practice of EPAS.

We believe that these attempts may be sincere and well meaning, but unfortunately are based on ignorance and misunderstanding. The first step towards a clear

understanding of the issues is to use clear, unambiguous terminology. Irrespective of whether EPAS is legalised in Australia or New Zealand, EPAS has no part in the ethical and professional practice of palliative medicine.

Professor Douglas Bridge is an Emeritus consultant at Royal Perth Hospital, clinical professor in the University of Western Australia's School of Medicine and Pharmacology, a consultant physician with WA Country Health Service, and is past president of the Chapter of Palliative Medicine, Royal Australasian College of Physicians. He writes on behalf of the following cosignatories:

- Dr Simon Allan, Arohanui Hospice, New Zealand.
- Dr Megan Best, University of Sydney, University of Notre Dame, NSW.
- Dr Mil Chan, North Adelaide, SA.
- Dr Louis Christie, Orange Health Service, Palliative Care Service, NSW.
- Professor Richard Chye, St Vincent's Hospital, University of New South Wales, NSW.
- Dr Maria Cigolini, Royal Prince Albert Hospital, Chris O'Brien LifeHouse, University of Sydney, NSW.
- Professor Katherine Clark, North Sydney Cancer Centre, Royal North Shore Hospital, University of Sydney, NSW.
- A/Professor Josephine Clayton, HammondCare, University of Sydney, NSW.
- Professor Sinead Donnelly, University of Otago, Victoria University of Wellington, New Zealand.
- Dr Derek Eng, Perth, University of Western Australia, WA.
- Dr Anthony Herbert, Lady Cilento Children's Hospital, QLD.
- Dr Annmarie Hosie, University of Technology Sydney, NSW.
- Dr Suharsha Kanathigoda, Canberra, ACT.
- Dr Martin Kennedy, Lady Davidson Private Hospital, Calvary Hospital, NSW.
- Professor David Kissane, Monash University, VIC.
- Dr Amanda Landers, University of Otago, New Zealand.
- Dr Lynn Lim, Royal Prince Alfred Hospital, Chris O'Brien LifeHouse, , NSW.
- Professor Melanie Lovell, HammondCare, University of Sydney, University of Technology Sydney,, NSW.
- Professor Roderick Macleod, HammondCare, University of Sydney, NSW.
- Dr Yvonne McMasters, palliative medicine specialist and activist, NSW.
- A/Professor Natasha Michael, Cabrini Health Monash, University of Notre Dame, VIC.

- Dr Wendy Muircroft, Southern Adelaide, SA.
- Professor Ian Olver, Sansom Institute for Health Research, University of South Australia, SA.
- Dr Riona Pais, Royal Prince Alfred Hospital, University of New South Wales, NSW.
- Dr Lawrie Palmer, University of Adelaide, SA.
- Dr Laura Pearce, South Coast, NSW.
- Professor Jane Philips, University of Technology Sydney, NSW.
- Professor Peter Ravenscroft, University of Newcastle, NSW.
- Dr Philip Redelman, St Vincents Hospital, NSW.
- CNC Joan Ryan, Royal Prince Alfred Hospital, Chris O'Brien LifeHouse, University of Sydney, NSW.
- Dr Merlina Sulistio, Cabrini Health, VIC.
- Dr Sarah Thompson, HammondCare, NSW.
- Dr Sarah Wenham, Broken Hill Hospital, NSW.

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