Template for letter writing: Medical aspects of Australian Euthanasia legislation

General points

1. Currently there is much misinformation in the media regarding medical care of terminally ill patients, in particular regarding analgesia and sedative use at the end of life. There is comprehensive evidence that therapeutic use of opioids and sedatives do not shorten life, in fact there is some evidence to suggest they prolong life.(1) There is also lack of understanding about the metabolic changes in terminal illness and reduced appetite which have been interpreted as doctors 'starving' these patients and hastening death.(2)
2. It has been claimed that practice of euthanasia by doctors is widespread and that the profession needs to be regulated. If such a practice does occur it is regarded as medical negligence, and laws already exist to control such behaviour.
3. The goals of medicine and healthcare involve the preservation of life where possible and comfort care when cure it not possible, while neither hastening nor deferring death. (The role of doctors is to assist/support a person in their healthcare and to try and achieve these goals.)
4. By altering the criminal law to allow one citizen to kill another without penalty is to make a fundamental change in the values of our society, that is, that we do not kill each other, even for reasons of mercy or compassion. Following this initial change in our law in which killing is no longer criminal, it will be easier to move the boundaries of who can be killed, which is likely given evidence from overseas jurisdictions where euthanasia and physician-assisted suicide have been legalised.(2) Review of the brief period when euthanasia was legal in the Northern Territory showed that guidelines did not protect vulnerable patients from inappropriate use of the law.(3)
5. Evidence shows that the wish to hasten death reduces in patients who receive good palliative care.(4) Furthermore, in jurisdictions where euthanasia is legal, pain is an uncommon reason for euthanasia requests. Psychosocial problems are more commonly a reason to request euthanasia.(5) Therefore it is not a failure of medicine that lies beneath the call for euthanasia and assisted dying.
6. Most patients at the end of life want to live, sometimes at any cost.
7. The successful doctor-patient relationship depends on a high level of trust, which would be eroded if the doctor could not be depended on to preserve life and assist a patient through periods of transition, adjustment and distress.
8. For these reasons, even if euthanasia or physician-assisted suicide is legalised in Australia, doctors should not be included in its execution. It significantly compromises the doctor/patient relationship.

Victorian legislation

The Victorian Inquiry into End of Life choices began on May 7, 2015 and was overseen by a cross party committee. As well as attending to a large number of Inquiry submissions, the committee also travelled overseas to countries where dying with dignity laws are in place. The final report of the Inquiry was tabled in Parliament on June 9, 2016. In all, there were 49 recommendations made in the report relating to palliative care, advance care directives and

assisted dying. The final recommendation was that the Victorian Government introduce a legal framework providing for assisted dying, by enacting legislation based on the assisted dying framework outlined in the report.

The Government responded to the voluntary assisted dying recommendations made in the Inquiry into End of Life Choices on December 9, 2016, saying that they would introduce an assisted dying bill into Parliament in the second half of 2017. The process was be boosted by the appointment of a Ministerial Advisory Committee to assist the Government in developing legislation.

The bill has not yet been introduced to parliament, but the Ministerial Advisory Committee released a discussion paper: Victorian-voluntary-assisted-dying-bill-discussion-paper

The language in the paper suggests that so-called safeguards for the legislation are in fact barriers to access for patients. Suffering is used as a justification for assisted death, but it is recommended that patients do not need to access available means to relieve suffering if they deem it intolerable. While patients need to be informed about palliative care, there is no requirement that palliative care services are involved in making known what options are available to help the patient. Patients may be prescribed lethal medication to take themselves, but doctors are required to administer the drug when patients cannot. There are no recommendations for how this will be monitored in the community. While it is recommended that conscientious objection to assisting death be recognised, it is suggested that referral to a non-objecting doctor should be obligatory in such a case. There is a suggestion that the cause of death on the death certificate should be the underlying disease, not assisted death. (**Please see the discussion paper for more details**

NSW legislation

A cross-party working group of five NSW MPs led by National Trevor Khan released a draft bill for public consultation on May 16 2017 and expect to introduce it to parliament in August. The draft bill would give a person over the age of 25 the right to request assistance from a medical practitioner to end their life. They must be experiencing severe pain or physical incapacity, and be likely to die within 12 months. Patients must be assessed by their primary doctor, then a specialist, as well as a psychologist or psychiatrist. Patients would then be allowed to self-administer a lethal substance to end their lives. They may also be assisted by a medical practitioner or nominated person. The process would include a cooling-off period of 48 hours, which starts once a request for assistance certificate has been completed. The bill would also enable a close relative of the patient to apply to the Supreme Court for a judicial review.

Note that severe pain is justification of access to this bill, but there is no mention of whether potential appropriate treatments or services have been accessed.

Recommended viewing: Winner of this year's Tropfest short film festival, The Mother Situation https://vimeo.com/204136643

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2. Laviano A, Meguid MM, Inui A, Muscaritoli M, Rossi-Fanelli F. Therapy insight: cancer anorexia–cachexia syndrome—when all you can eat is yourself. Nature clinical practice Oncology. 2005;2(3):158-65.
3. Kissane DW, Street A, Nitschke P. Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia. The Lancet. 1998;352(9134):1097-102.
4. Breitbart W, Rosenfeld B, Gibson C, Pessin H, Poppito S, Nelson C, et al. Meaning-centered group psychotherapy for patients with advanced cancer: A pilot randomized controlled trial. Psychooncology. 2010;19:21-8.
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