

Appendix

TERMINAL ILLNESS AND CARE OF THOSE WHO ARE TERMINALLY ILL

In July 1995 the Victorian Council of Churches and the Executive of the National Council of Churches in Australia, representing a wide range of churches (including the Uniting Church), made strong statements rejecting euthanasia.

The “terminally ill” person is one who (according to professional medical opinion), is engaged in irreversible biological processes that will lead to imminent death. To quote Prof John Hinton: “Fatal conditions are often remarkably free from discomfort. There are the oft quoted words of the dying William Hunter, physician and anatomist, ‘If I had strength enough to hold a pen, I would write how easy and pleasant a thing it is to die’....Friends and relatives of the dying usually have little knowledge of the protective function of diminished consciousness. Someone about to die may look so ill, or be so confused in mind, that the onlookers mistake this for suffering and feel helpless because of their inability to relieve an imagined distress Nevertheless, many do suffer a lot in their mortal illness.” (Hinton J, *Dying*, Penguin Books Ltd, Harmondsworth, Middlesex, England 1972, 23.)

Palliative care is essential to ensure comfort and peace for those who suffer. Despite all the progress that has been made, many patients, particularly in rural areas, do not have access to expert palliative care staff and facilities.

Wherever death takes place, the reflection of Dame Cicely Saunders is relevant to terminal care: “The phrase ‘watch with me’ comes from the story of Jesus facing death in the Garden of Gethsemane (Matt. 26:38) and sums up the deepest need of any person facing death or desolation. It did not mean ‘take away’, it could not have meant ‘understand or explain’ – its simple and costly demand was to ‘stay there’.” (Saunders C, *The Management of Terminal Disease*, Edward Arnold 1978, 8.)

There is a better way than euthanasia to have “a good death” and to “die with dignity” and for doctors and nurses to “help patients to die” as comfortably as possible. This is achieved with the aid of pain control and palliative care. These we believe should be each person’s last rights.

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Assembly of Confessing Congregations within the Uniting Church in Australia

Social Responsibility Commission

A Christian Response to Euthanasia and Medically Assisted Suicide

Christians have traditionally been motivated by compassion to relieve suffering, heal the sick and support life. At the end of every life, death may include suffering, whether physical and/or existential.

Thanks to the widespread belief in autonomy and self-determination, some people believe that everyone should have the right to end their life when they wish, in order to avoid the pain and suffering of terminal illness. Members of Exit International go further; they argue for the right to end life even when illness is not terminal, if patients claim to have “no quality of life”.

In these views we see that those in favour of euthanasia mount an argument that usually has two main propositions both of which must be rejected by Christianity. The first proposition advocates a right to self-murder when a person has an incurable illness. The second proposition, which is often entwined with the first, advocates the right to euthanasia when a life is judged, by an individual or others, to no longer be socially useful. (The phrase “socially useful” may sound harsh but it is the concept that lies behind such an apparently noble motive as not wanting to be a burden on others.)

Christianity has to reject these arguments because in Jesus Christ God has shown himself to be the creator, preserver and redeemer of life. A consequence of this state of affairs is that only God has the right to end life. A second consequence is that God holds human life itself to be valuable regardless of the contribution a person is able, or not able, to make to social life. A third consequence is that only God knows the purpose and goal of life, even disabled and diseased life.

DEFINITIONS

Euthanasia (Greek: eu – good, thanatos – death) now refers to intentional killing by a medical practitioner in order to relieve a patient’s suffering. It may be:

- Voluntary – killing patients who are fully informed and have requested it.
- Non voluntary – killing patients who cannot give consent because of unconsciousness or inability to understand or communicate.
- Involuntary – killing patients either contrary to their will or without consulting them.

(Yu V, A theological reflection on euthanasia, delivered to the International Christian Medical and Dental Association XIII World Congress, Sydney, July 2006.)

On the other hand **unrelieved pain** may cause stress and may accelerate death. **Pain relief** can improve the quality of life, help a person to sleep better and move about more freely. Mobility may diminish complications such as pneumonia, bed sores and blood clots, all of which may hasten death.

Certainly some patients suffer greatly from problems other than pain. These are addressed by palliative care. Symptoms such as vomiting, breathing difficulties, anxiety and depression are treated as well as pain. Some patients may have communication, relationship, spiritual or financial problems which may add to what is called the “total” pain. Palliative care teams have access to doctors, nurses, pharmacists, social workers, chaplains, physio- and occupational therapists, dietitians and volunteers.

The illness may be a great burden to the patient’s family and carers, and palliative care addresses their needs also. The pain of separation and loss cannot be avoided by either medicines or euthanasia, but palliative care may provide support and someone to share the grief.

During the past 40 years there have been enormous advances in pain and symptom management and palliative care with training of doctors, nurses and allied health personnel, development of palliative care services (free standing units, special wards, in-patient support teams and domiciliary care), clinical and basic research, development of frameworks, pathways and guidelines for patients in all kinds of situations.

THE CHURCHES’ ATTITUDE TO END OF LIFE CARE AND EUTHANASIA

Hospices to care for the dying have been set up and administered by Christian organisations for over a hundred years. Those close to death have been cared for compassionately as an expression of Christian commitment, as the Sisters of Charity say, “Caritas Christi urget nos – The love of Christ compels us.” (2 Cor. 5:14.) (See *Appendix overleaf.*)

Belief in the possibility of pain relief has been undermined by frequent references to the “doctrine of double effect” in which it was argued that drugs such as morphine when used for pain relief might incidentally shorten life. Prof. Michael Ashby, Professor of Palliative Care at Monash University, stated: “The accepted practice (of which there are nearly 20 years of safe experience) is to adjust the regular dose upwards according to the ‘top-up’ requirements to keep the pain under control, balanced against the incidence of side effects. Despite an extensive and sustained international campaign by the World Health Organisation [WHO], many doctors still believe they are causing or hastening the death of patients, despite the absence of any evidence to support this view.” (Letter to *MJA* vol 165, 21/10/96.)

However, we need to emphasise that the widely held belief that morphine shortens life can have unfortunate consequences.

- Patients who are prescribed morphine frequently think this means that they must be close to death.
- Many patients, believing pain killers will shorten their life, decide to put up with their pain. This results in unnecessary suffering.
- Not infrequently, dying patients, relatives or carers may believe that morphine is causing or contributing to their death and they or their relatives request (or demand) that the morphine be ceased. This results in avoidable pain.
- Doctors and nurses who have indicated in surveys that they had “hastened death” may have believed they were responsible if a patient died after receiving morphine, although actually the patient had died of the disease while the morphine merely relieved the suffering.
- The “doctrine of double effect” may be regarded as a legal and ethical loophole from which to argue for euthanasia.

Of course a person **can** be killed by giving a large overdose of an opioid drug such as morphine. However there are several medications which can reverse the effect of an overdose. Morphine has a wide margin of safety.

Physician assisted (or medically assisted) **suicide** occurs when a doctor provides the means for self-killing to a person who has requested it. (Pollard B {1994} *The Challenge of Euthanasia*, Mount Series, Little Hills, Crows Nest p18.) The term medically assisted dying (or physician assisted dying) should be reserved for the proper actions of doctors who assist dying patients by giving psychological and spiritual support and treating symptoms that occur in the terminal phase of their life.

“**Passive euthanasia**” is a term which should be abandoned as it has been used to describe actions that do not involve intentional killing. These may be:

- So-called “letting die” – withholding or withdrawing treatment which is futile, burdensome or of insufficient benefit to the patient. Nothing is done to kill and the patient dies from his or her disease, i.e. a natural death.
- Providing effective pain relief. It is erroneously suggested that giving escalating doses of opioid drugs such as morphine for the relief of pain and other symptoms will incidentally shorten life. (This is considered under palliative care.)

THE LEGAL SITUATION

In **Australia**, euthanasia is regarded as homicide in all states.

Euthanasia and physician assisted suicide have been discussed at length over many years by Victorian members of parliament.

In 1987 the Victorian Government held a wide-ranging “Inquiry into Options for Dying with Dignity” and passed the Medical Treatment Act 1988 (commonly known as the “death with dignity” law) which allows a person to refuse life-sustaining treatment.

The Medical Treatment (Enduring Power of Attorney) Act 1990 allows a person to appoint an agent to make decisions on his/her behalf if the person is unable.

In 2003 the Supreme Court of Victoria ruled (*Gardiner v BWV*) that gastrostomy feeding of a person in a permanent vegetative state may be withdrawn.

Then in September 2008, after months of thoroughly debating the issue, a bill to legalise euthanasia was rejected by a clear majority (25 to 13) in the Upper House of the Victorian Parliament.

The parliaments of Tasmania, South Australia and Western Australia have recently refused to pass euthanasia legislation.

Under the Northern Territory's Rights of the Terminally Ill Act 1996, euthanasia and physician assisted suicide were legal for a nine-month period until the law was overturned by Federal Parliament in 1997.

Suicide or attempted suicide is not an offence in Australia but assisting or encouraging another person to commit suicide is an offence in all states and territories.

Euthanasia is illegal in all Western countries except The Netherlands, Belgium and Luxemburg, where it was decriminalised in 2002, 2002 and 2009 respectively.

In Switzerland a person is allowed to help another to commit suicide provided he or she does so for altruistic reasons. Nevertheless euthanasia is illegal.

The American states of Oregon and Washington have decriminalised assisted suicide in 1997 and 2009 but euthanasia is illegal in both states.

The parliaments of United Kingdom, France, Canada and nine states of USA have all recently refused to pass euthanasia legislation.

- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

<http://www.who.int/cancer/palliative/definition/en/> (accessed 22/10/10).

The modern hospice movement commenced with the vision of Dr Cicely Saunders and her colleagues at St Christopher's Hospice in London, which was opened in 1967. They pioneered scientific methods of pain management, addressed problems of the whole person and the family, and attended to aspects of grief and loss.

The hospice movement has spread throughout the world, although in some cases the term "palliative care" is preferred. To "palliate" is a word derived from the Latin, meaning "to cover with a cloak". In English it means "to alleviate the symptoms of a disease" or "mitigate the suffering of it".

PAIN

Pain is probably the symptom patients fear most. Quite likely this has been encouraged by the Gallup poll question stressing **great** pain, **hopelessly** ill, with **no** chance of recovery.

and friends to request it, when they fail to recognise that it is sometimes their own, rather than the patient's distress which they wish to end.

PALLIATIVE CARE

It is essential that suffering be relieved, whether the suffering is due to pain, other symptoms, depression or loneliness. Relief is offered by treating symptoms and giving support to patients and family so that individuals may enjoy life as fully as possible until they die. This is called "Palliative Care". It recognises that even if you cannot **cure** you can **care**. This is the essence of the modern hospice/palliative care movement.

Although the Voluntary Euthanasia Society now calls itself "Dying with Dignity Victoria", euthanasia is not necessary for a dignified death. Preceding the Medical Treatment Act 1988 (commonly known as the "Death with Dignity" law) the Victorian Government conducted a wide-ranging "Enquiry into Options for Dying with Dignity". It did not recommend euthanasia or physician assisted suicide. Dignity is in the eye of the beholder. We do not believe that death by suicide or euthanasia is more dignified than death by natural causes, occurring "when our time has come" with symptoms and problems alleviated by palliative care if necessary, and in the company of those who love and care.

W H O DEFINITION OF PALLIATIVE CARE

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;

SHOULD THE LAW IN AUSTRALIA BE CHANGED?

It has been stated that over 80% of the population support changing the law to allow euthanasia. Members of the general public do not have the opportunity to become well-informed like members of parliament. They may be phoned by a pollster and asked their opinion while they are cooking dinner or watching TV.

The hypothetical question asked by Morgan Gallup polls since 1946 is calculated to evince positive responses. People are asked : "If a **hopelessly** ill patient, in **great** pain, with **absolutely no** chance of recovery asks for a lethal dose, so as not to wake again, should a doctor be allowed to give a lethal dose or not?"

The poll question is not "Do you think euthanasia should be legalised?" but "Would you favour dying in agony or euthanasia?" Naturally, many opt for euthanasia. Pain relief is not stated as an option, since the hypothetical patient's pain is described as "great" – that is, unable to be relieved. Advances in pain management since 1946 make this situation extremely unlikely today, because new drugs and analgesic techniques are being developed continually. The Morgan Gallup poll question does a disservice to dying patients because it suggests they might suffer great pain which can only be relieved by death.

Many opinion surveys asking "Should euthanasia be legalised?" are self-selected responses to newspaper polls which may not reflect the views of the whole population. In any case, legislation should be based on informed opinion, rather than public opinion.

Many people are rightly concerned with issues of autonomy and dignity and believe euthanasia would provide control over the time and manner of dying. One correspondent complained "No one is trying to change their beliefs, or force people to do something they don't want to do. I respect their belief, and I would defend their right to choose how they

end their life, but I don't understand why they don't show me the same respect". (Manning V, A long goodbye, *Melbourne Weekly* 27/10/10.)

Opinions expressed from a religious point of view are sometimes treated with contempt. For example, D Flounders wrote, "I detest the political mealy-mouthed 'God-botherers' in Canberra who danced to the religious lobby's tune. It's my life, not theirs, and they should have the courtesy to allow me to make the final BIG decisions while I am able." (*The Age* 30/3/07.)

However there are several reasons and rational arguments apart from appeals to religious beliefs why a law allowing voluntary euthanasia or physician assisted suicide may have impacts far beyond the immediate needs of people seeking to end their lives.

However much we believe in self-determination or autonomy, sick and elderly people are extremely vulnerable to pressure from relatives to request euthanasia. If euthanasia were an option it would add to the distress and guilt of those who might think of themselves as too great a burden on others. The pressure of being made to feel a financial handicap, a worthless burden or as "having passed one's use-by date" is incompatible with being an autonomous individual.

Professor Robert Blanchard of the University of Manitoba states: "The desire for individual autonomy ... does not exist in a vacuum. There is a need to reflect on the impact of any decisions on the quality of our society, on our humanity. To encourage and make possible the intentional killing of myself or my fellow is not good for our society and will backfire." (Letter *CMAJ* 10/8/2010, 182 (11), 1213-4).

Professor Alistair Campbell, director of the Bioethics Research Centre of the University of Otago, New Zealand, has asked: "But is a society in which all we have is merely respect for the plurality of views really a fulfilling place to be? What happens to the self in this sea of subjectivity, when all are respected as individuals but nothing binds us to a common human end?"

PHYSICIAN ASSISTED SUICIDE

Some jurisdictions do not permit euthanasia but do allow physician assisted suicide. This may be preferable as the patient kills him/herself, so it is more likely to be voluntary and free from duress. The doctor may feel more removed from the act, but is still intimately involved in aiding and facilitating the suicide.

We deplore the many suicides among young people, who feel their problems are insoluble, become depressed and try to "end it all". It would give mixed messages if we were to encourage those with chronic illness, depression and other problems to opt out of life.

In Australia suicides among all ages claim about 2,500 lives a year. Given this present tragedy, assisted suicide legislation would lend "state" approval for suicide as a valid option and therefore undermine the good that is being done on so many fronts to combat this. It would give approval for the young to consider what they would otherwise not consider.

Dr Philip Nitschke also argues that anyone – even troubled teens – should have the right to kill themselves: "...all people qualify, not just those with the training, knowledge, or resources to find out how to 'give away' their life. And someone needs to provide this knowledge, training, or recourse necessary to anyone who wants it, including the depressed, the elderly bereaved, the troubled teen." *National Review Online*, 5 June, 2001. <http://www.nationalreview.com/interrogatory/interrogatory060501.shtml>

Australia must not go down the path of suicide approval. We should make all efforts not to add to the philosophy already apparent in our society that says: "If things get too hard, I'll just kill myself."

Actually it is rare in the experience of those who care for people at the end of life for a patient to request euthanasia or suicide. When life is threatened it usually becomes very precious. It is less unusual for family

of the colon: An unusual case. *MJA* vol 144, 17/2/1986 211-213).
As with capital punishment, if you get it wrong, it's too late!

CAUSES OF REQUEST

It is essential to uncover what underlies a request for euthanasia or assisted suicide. The desire may fluctuate from time to time. Perhaps a person has outlived the life-span predicted by the doctor and the patient feels he/she has misled the friends who commiserated and said "goodbye".

It may often be related to **depression**. Researchers have demonstrated that the issues which drive interest in physician assisted suicide are not related to medical prognosis or even pain control, but rather to depression, lack of social support and hopelessness. (Chochinov HM, Wilson KG, Enus M, et al (1995) Desire for death in the terminally ill. *American Journal of Psychiatry*, 152, 1185-1191. Breitbart W, Rosenfeld B, Pessin H et al (2000) Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer *JAMA*, 284, 2907-2911.)

Palliative care practitioners have studied expressions of a desire for hastened death, and have made recommendations for its management. (Hudson P, Kristjanson L, Ashby M, Kelly B, Schofield P, Hudson R et al. (2006). Desire for hastened death in patients with advanced disease and the evidence base of clinical guidelines: a systematic review. *Palliative Medicine*, 20(7), 693-701. See Hudson P, Schofield P, Kelly B, Street A, O'Connor M, Kristjanson L et al. (2006). Responding to desire to die statements from patients with advanced disease: recommendations for health professionals. *Palliative Medicine*, 20 (7) 703-710.)

Professor Margaret Somerville, director of the McGill Centre for Medicine, Ethics and Law in Montreal, Canada, was asked by an interviewer, "So we can only have one tone in a pluralistic society?" She replied, "You can only have one fundamentally ethically legal tone about something that is as fundamental as whether you can kill each other. You can't both kill each other and not kill each other. You have to choose."

We also believe euthanasia and physician assisted suicide should not be legalised due to the impossibility of framing adequate legislation.

The Hon. Nick Gorian in speaking against the Western Australian Voluntary Euthanasia Bill 2010 said, "It is a legal impossibility to protect against **involuntary** euthanasia when voluntary euthanasia is legalised. Duress means pressure or compulsion to force a person to do something against his or her will. A contract made under duress is voidable by the person coerced. If I enter into a commercial contract with somebody and put him under pressure and exercise duress so that he is under duress when he signs the contract, he will have the opportunity after the event to go to a court of law and seek redress. In this situation there is no possibility for a victim of duress in a euthanasia contract to seek any redress after the event. That is why I say that it is legally impossible for us to provide sufficient safeguards." (2nd reading of bill 21/9/2010.)

Dr Brian Pollard has stated that safe, legalised voluntary euthanasia is a myth. "Members of parliament alone have the singular responsibility of making safe laws which cannot imperil the lives of innocent people who do not wish to die. It is evident that the authors of those bills have not read any of the extensive literature on this subject because they invariably include, as so-called safeguards, provisions which are well-known not to work in practice. A common feature of Australian draft euthanasia bills is their touching reliance on the fact that certain things will happen, just because the draft prescribes it. If that were true, no crime would ever be committed because they are all currently forbidden

by some law.” (Pollard B. Why Safe Voluntary Euthanasia is a Myth. *Quadrant* Jan-Feb 2011 No. 473 {Vol LV No 1-2} 26-28.)

Some doctors in Australia have admitted that they have broken the law and killed patients who requested it. It has been suggested that euthanasia should therefore be legalised to control the practice. We already have a law which says “do not kill patients”. If there were a law setting limits to euthanasia would they disregard this law if they disagreed with its limits, or kill those who had not requested to die, but whose life they deemed to be “not worth living”?

The British House of Lords Select Committee on Euthanasia stated that it is impossible to set secure limits on voluntary euthanasia and “to create an exception to the general prohibition of intentional killing would inevitably open the way to its further erosion whether by design, by inadvertence or by the human tendency to test the limits of any regulation”. (Editorial. Their lordships on euthanasia. *Lancet* 343:19 Feb. 1994: 430-31.)

Proponents always speak of “voluntary” euthanasia. However, in countries where there is legislation permitting voluntary euthanasia, it is carried out in many cases without the patient’s explicit request. E.g. in the Netherlands in 1991, there were 1000 cases of **involuntary** euthanasia (Van der Maas PJ et al, Euthanasia and other medical decisions concerning the end of life. *Lancet* 338: 1991: 669-674). In 410 of these cases the patient was incompetent but the other 590 patients were competent and the decision was made by the doctor, with or without the relatives. (Pijnenborg L et al, Life-terminating acts without explicit request of patient. *Lancet* 1993: 341: 1196-99.)

Despite the obligation to notify the Coroner an article from The Netherlands stated that “a recent study among GPs discovered that 38 per cent of euthanasia cases were never reported. Generally, doctors are making their reports more acceptable than they are in reality, and in case of any complications or in adherence to the rules, the case is not

reported.” (Zylicz Z The story behind the blank spot. *Amer.J.Hosp. & Pall.Care*, Jul-Aug 1993: 30-34.)

In a recent study in Belgium, where euthanasia has been legal since 2002, 120 of 248 nurses interviewed admitted that they had taken part in “terminations without request or consent” of the patients. (Inghelbrecht E, Bilsen J et al. The role of nurses in physician-assisted deaths in Belgium, *CMAJ* (15/6/2010) 182 (9) 905-910.) This has been called “the slippery slope”!

There are other reasons why legislation for euthanasia would be unsound:

Medical opinion is not totally foolproof. With modern technology, **errors in diagnosis** are rare, but still possible. Dr Jack Kevorkian (a retired American pathologist) assisted in over 100 deaths. Of 69 who died between 1990 and 1998 and were investigated by an autopsy performed at the Oakland County District Office, Michigan, **only 25%** were found to be terminally ill. Five patients had no anatomical disease at all. 71% were women. (Roscoe LA, Malphurs JE, Dragovic LJ, Cohen D. Dr Jack Kevorkian and Cases of Euthanasia in Oakland County, Michigan 1990-1998, *NEJM* 7/12/2000, vol 343, no 23, 1375-1376.)

Patients who have been successfully treated for cancer may still believe they will succumb to the disease. In Australia in May 2002 Mrs Nancy Crick, who had been treated for cancer and believed she was continuing to suffer as the result of the cancer, was “helped to die” with advice about suicide. No trace of cancer was found at her autopsy.

Prognosis may be very difficult to estimate accurately. Some patients far outlive their estimated life span. Proposed laws may permit euthanasia if a person has less than six months to live – but this might be quite difficult to assess. Although exceptionally rare, there are well documented cases of spontaneous cure of widespread cancer (e.g. Beechey RT, Edwards BEL, Kelland CH, Case report. Adenocarcinoma