LEGALISE EUTHANASIA AND COMPASSIONATE SOCIETY DIES TOO

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If you love your parents, respect your children, care for your society and think compassionately about your world then it is time to open your heart and brain to what happens when a jurisdiction legalises killing or, as it is called, euthanasia.

The justification for euthanasia lies in human rights, individual autonomy and relieving pain — all worthy ideas, and that may prompt the question: why then is euthanasia still opposed by most nations, most medical professional bodies around the world and the Australian Medical Association?

The reason is not hard to find. It is because crossing the threshold to euthanasia is the ultimate step in medical, moral and social terms. A polity is never the same afterwards and a society is never the same. It changes forever the doctor-patient bond. It is because, in brutal but honest terms, more people will be put at risk by the legislation than will be granted relief as beneficiaries.

The argument against euthanasia has endured for many years: it leads, on balance, to a less compassionate society that creates a new series of moral and practical hazards for itself. It is a disproportionate response to the real problem of patient pain that needs more care and money. It is because a society that legalises killing has to change fundamentally in terms of the ethics of its doctors, its medical ethos, its family relationships and its principles of human life. Belgium, having legalised euthanasia in 2002, offers a tragic picture of what can happen to a country just a few short years later.

In this debate the principle of individual autonomy is vital. Adults, as much as possible, should be able to exercise choices over their medical treatment. That means declining treatment that can keep them alive. There is no real dispute about that.

Euthanasia is different: it is an act that terminates life. It is, therefore, by definition not a private affair; not just about a patient's right. It is a public and society-wide issue because it involves the state legalising killing subject to certain conditions. That is a grave step and it concerns everyone.

AMA head Michael Gannon tells Inquirer: "The current policy of the AMA is that doctors should not involve themselves in any treatment that has as its aim the ending of a patient's life. This is consistent with the policy position of most medical associations around the world and reflects 2000 years of medical ethics."

There are three foundational points in this debate. First, in relative terms the proportion of people dying in acute pain is declining because palliative care methods have been enhanced. There is wide agreement among experts that most physical pain at life's end can now be managed — this is a critical trend but cannot conceal the fact painful deaths still exist and become the main argument for

legal change. But euthanasia should not be seen as a substitute for palliative care — that would be a medical and moral blunder.

Second, where euthanasia is legalised the record is clear — its availability generates rapid and ever expanding use and wider legal boundaries. Its rate and practice quickly exceeds the small number of cases based on the original criteria of unacceptable pain — witness Belgium, The Netherlands, Switzerland and Oregon. In Belgium, figures for sanctioned killings and assisted suicide rose from 235 in 2003 to 2012 by last year. In the Netherlands they rose from 2331 in 2008 to 5516 last year.

These figures come from Labor MLC Daniel Mulino's minority report in the recent Victorian parliament committee report recommending euthanasia. His conclusion is that "the negative consequences arising from legislation far outweighs the benefits arising in that minority of cases".

Experience in other jurisdictions leads to the unambiguous conclusion: the threshold event is the original legalising of euthanasia. After this there is only one debate — it is over when and how to expand the sanctioned killings. Claims made in Victoria that strict safeguards will be implemented and sustained are simply untenable and defy the lived overseas experience as well as political reality. There are many questions. If you sanction killing for end-of-life pain relief, how can you deny this right to people in pain who aren't dying? If you give this right to adults, how can you deny this right to children? If you give this right to people in physical pain, how can you deny this right to people with mental illness? If you give this right to people with mental illness, how can you deny this right to people who are exhausted with life?

Third, culture and values will change to justify the death process. Consider the situation of one of Belgium's most famous doctors, Wim Distelmans, applauded as a human rights champion. Having killed more than 100 patients, he is a celebrity, gives talks around the nation and is lauded as a man who "cannot stand injustice". He told *Der Spiegel* that giving a lethal injection is an act of "unconditional love".

In Belgium, because so many are killed, the act must be converted into the exemplar of moral and medical compassion.

"Who am I to convince patients that they have to suffer longer than they want?" Distelmans said in one of the most astonishing articles of our time ("The Death Treatment" by Rachel Aviv, *The New Yorker*, June 22, 2015).

It is the story of how an adult son, Tom Mortier, sought justice after Distelmans killed his mother without Mortier's knowledge. Distelmans was appointed chairman of the Federal Control and Evaluation Commission, whose job is to assess that doctors have complied with Belgian law. He told *The New Yorker*: "We at the commission are confronted more and more with patients who are tired of dealing with a sum of small ailments — they are what we call 'tired of life'."

Though their suffering derived from social as well as medical concerns, Distelmans said he regarded their pain as incurable. The article reported that 13 per cent of Belgians who were euthanised last

year did not have a terminal condition. In Belgium euthanasia and suicide march together — it also has the second highest suicide rate (excluding euthanasia) in western Europe.

The most chilling aspect in a chilling story was Distelmans's moral superiority in dealing with Mortier, prompting Mortier to write later: "I loved my mother for more than 30 years and I wanted her to live; Dr Distelmans loved her so much — 'unconditionally' — that after a few brief consultations over six months he gave her a lethal injection."

Once you sanction euthanasia you open the door to euthanasia creep. The human heart will always respond to the incentives of the law. Cross the threshold and doctors will be encouraged to think it is their job to promote the end-of-life. Sick people, thinking of families, feel obliged to offer up their deaths. Less worthy people exploit the death process for gain. In Belgium children can now be euthanised. Would this have been acceptable when euthanasia was legalised in 2002? No way.

The article quoted a professor of psychiatry at the University of Leuven, Dirk De Wachter, calling euthanasia a humanist solution to a humanist dilemma. "What is life worth when there is no God?" he asked. "What is life worth when I am not successful?"

There are an infinite number of similar questions: what is life worth when you are lonely or depressed? De Wachter said he had recently euthanised a woman, not suffering from clinical depression but in a condition where "it was impossible for her to have a goal in life".

Pro-euthanasia advocates in Australia are split when dealing with Belgium and The Netherlands between defending their practices or saying they are not relevant to our debate. The latter is false. These countries are highly relevant — as classic studies in how the euthanasia culture takes grips of a nation's moral sense. It is sanctioned in terms of love, liberation and compassion — the ultimate service one human can render another.

The recent Victorian parliamentary report Inquiry into End of Life Choices recommended that people be assisted to die by being prescribed a lethal drug to be taken by themselves or administered by a doctor. It outlined a series of strict guidelines as eligibility criteria — approval by a primary doctor and a second doctor only for patients suffering at the end of life. The condition must be serious and incurable. The request must come from the patient and be free of coercion, be properly informed and be made three times: verbal, written, then verbal again.

There is significant support for euthanasia in the Victorian cabinet and in the opposing frontbench. A bill is certain in the life of the present parliament. Expectations are that it will be passed.

The AMA's Gannon says the association is conducting a review of its euthanasia policy. He says this is "routine" and not prompted by "recent events". He highlights the paradox of euthanasia. "It is only a rich country issue," Gannon says. "There is no one in the developing world talking about terminating the lives of patients." The AMA review will be completed in mid-November.

The pro-euthanasia group within the AMA hopes to shift its policy from opposition to neutral, mirroring the shift made in Canada — and that would be a significant step. In its evaluation the AMA

must focus beyond the issue of patient autonomy to confront the question of doctor-patient relations and how they would change under euthanasia.

A critical feature of the Victorian report is the belief that a small number of people seeking euthanasia can be helped without any significant downside for society. It seeks to achieve this through robust eligibility criteria and the repudiation of any “slippery slope” problem with euthanasia in jurisdictions such as Oregon, The Netherlands and Switzerland.

Such optimism is heroic and typical of the euthanasia debate. It is echoed in nation after nation, year after year. It testifies to the deepest humanist conviction that mankind and wise governments can introduce euthanasia regimes with the necessary legal safeguards and the necessary regulatory protections to manage the promotion of death to ensure only net gains for the social order.

It is surely extraordinary that people sceptical of the ability of governments to get trains running on time fool themselves into thinking they can confidently manage a regime that sanctions the termination of human life.

The minority report from Mulino provides statistics showing there has been a sustained increase in deaths in all jurisdictions, no evidence that growth rates are plateauing with compound annual growth rates ranging from 13 to 22 per cent, which Mulino says has to be regarded as “extremely high”. He says the total number of cases in Belgium has increased by 756 per cent over 12 years and in Oregon is 725 per cent higher across the 17 years since initial legislation.

What sort of society is evolving if these growth rates continue? Why cannot we rationally confront and answer these questions? What drives the rise in deaths?

Munilo says the evidence reveals euthanasia and assisted suicide regimes “come under immediate pressure as soon as these schemes are enacted”. First, there is pressure to widen the law and second is the pressure to interpret more generously its implementation. And we think Australia is exempt?

There are many examples. In Canada, there are advisory group recommendations to extend the law to children. In Belgium extending euthanasia to dementia patients is under examination. The Netherlands is considering allowing patients to make pre-dementia declarations.

The trend and logic is unassailable: once legislated the principle of euthanasia is settled and the practice of euthanasia is widened, if not by law then by administrative laxity and de facto regulatory sanction. Of course, many euthanasia cases are never declared.

A 2012 report by the European Institute of Bioethics said: “Initially legalised under very strict conditions, euthanasia has gradually become a very normal and even ordinary act to which patients are deemed to have a right.”

Many advocates in Australia use the rights language. Once this takes hold, then holding back the tide is near impossible. The upshot in The Netherlands is that the type of patients seeking euthanasia has

changed with a shift to those with psychiatric illness. Mobile clinics offering free lethal injections are now in operation.

Mulino refers to an Oregon Public Health Division report looking at 132 deaths and finding that 48 per cent listed being a burden on family, friends or caregivers was a concern. When the Belgian law was passed politicians insisted that patients with psychiatric disorders, dementia or depression would be excluded — yet the prospect now is for an escalation in these categories.

Vulnerable people are right to feel uneasy if Australia crosses the legal threshold. In truth, it is virtually impossible to ensure all acts of euthanasia are voluntary. The elderly, lonely, handicapped and indigenous need to think how such laws mat affect them and their self-esteem.

In short, the foundational claims in the majority Victorian report of no “slippery slope” and effective “safeguards” do not pass the test of evidence, experience or careful analysis. This goes to the question of whether Australia will legislate on false and misleading assumptions that reflect ideological and political propositions.

On the pivotal and related issue of palliative care, Australia suffers a moral and humanitarian failure — and the Victorian report has responded with a strong set of recommendations.

Palliative Care Australia chief executive Liz Callaghan tells Inquirer: “The practice of palliative care does not include euthanasia or physician-assisted suicide, and palliative care does not intend to hasten or postpone death. PCA believes the Australian government needs to increase access to palliative care.

“Currently 70 per cent of Australians want to die at home but only 14 per cent do. We believe more needs to be done to ensure that this can happen. Access to integrated, comprehensive support and pain/symptom management is often inadequate, inequitable or may not meet patient needs.”

Callaghan says evidence is that pain management improved from 2011 to last year based on data collection from 115 specialist palliative care services looking after 20,000 patients needing pain management. She says PCA believes more needs to be done to ensure people are better educated about their end of life care choices and palliative care. The PCA believes any request for euthanasia requires “a respectful and compassionate response”, with Callaghan saying euthanasia is an issue for parliaments.

It is ironic this week that more evidence has emerged about the shocking impact of suicide in this country, particularly for Australians aged in the 15 to 44 age group. How, pray, does legalising euthanasia help the campaign against suicide? The most bizarre notion this week was the suggestion that legalising euthanasia may lower the suicide rate.

In many ways this entire debate is about how to interpret love and care in the context of death. Hug the person you love. But realise this is also about deciding the degree of discretion doctors have dealing with death. It may be good for a doctor to follow a patient’s wish for a lethal injection but that must be assessed against the total social impact of a regime that allows life to be terminated.

If we proceed then life will change, there will be a “slippery slope”, your relationship with your doctor will be different, the vulnerable will have reason to feel uneasy, the push to make euthanasia a right will be inevitable, the frail will feel obliged to volunteer and our values as a community will shift more quickly than you appreciate.

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