

WRONGFUL DEATHS BY ASSISTED SUICIDE OR EUTHANASIA

NO ACCESS TO PALLIATIVE CARE

Is assisted suicide needed to deal with physical pain?

There is a telling disconnect between the focus of assisted suicide and euthanasia laws **when they are being proposed** and **after they have been implemented**.

During the proposal phase the focus is almost universally on an alleged group of hard cases, few in number, who, it is said, are suffering unbearable physical pain or other physical symptoms that cannot be relieved by even the best palliative care. This claim is based largely on anecdotal evidence, often from earlier decades before recent improvements in palliative care.

- Proponents of assisted suicide laws falsely claim it is needed to relieve physical pain in a small number of hard cases
- Palliative care experts say that pain can be alleviated, including by the use of palliative sedation in some cases
- Physical pain is not among the main reasons people in Oregon give for seeking assisted suicide; loss of autonomy and being a burden on others are more common concerns
- Ian Haines is a medical oncologist who has changed his mind on euthanasia due to recent developments in palliative care
- The Australian Pain Management Association says legalising assisted suicide *"may lead to government having an opportunity for people to end their life with the help of another person rather than investing in early pain management support and the medical treatment and community support that people need in order to have a 'good death' and die with dignity"*

Assisted suicide for pain management?

After implementation it becomes clearer that the real focus is on autonomy – an alleged right to assistance to die at a time of one's own choosing for any reason.

Proposals to legalise assisted suicide for a select group of people often include a criterion such as *"suffering from a serious and incurable condition which is causing enduring and unbearable suffering that cannot be relieved in a manner the patient deems tolerable"*.

Proponents often claim that palliative care cannot relieve all pain.

For example the Victorian parliamentary committee report [End of Life Choices](#) falsely claimed (p. 206) that palliative care specialists gave evidence that “not all pain can be alleviated”.¹ Footnote 809 references “*Palliative Care Victoria, Submission, pp. 14–15*”. This is most misleading as what that [submission](#) actually states is that in the rare cases when all other methods of palliation for pain and other symptoms fail, palliative sedation therapy is available to provide adequate relief of suffering.²

Palliative Care Victoria: pain can be alleviated

The Palliative Care Victoria submission relevantly states:

Achieving the effective management of pain and other symptoms is a high priority in the care of people with a life limiting illness and people who are dying. Where these symptoms are not readily alleviated by general health and care services, a referral to access the specialised expertise of palliative care services should be made. In most cases, specialist palliative care teams are able to address the person’s physical pain and other symptoms and to respond to their psycho-social, emotional, spiritual and cultural needs so that they are able to live and die well with dignity. However, a small minority of patients experience refractory symptoms such as agitated delirium, difficulties breathing, pain and convulsions.

Refractory symptoms are defined as:

“pain or other symptoms for which all possible treatment has failed, or it is estimated that no methods are available for palliation within the time frame and the risk-benefit ratio that the patient can tolerate.”

A patient with refractory (unrelieved) distress “must have received skilled multidimensional management directed at the physical, psychological and existential dimensions of the symptom before a symptom is considered refractory.” Prudent application of palliative sedation therapy may be used in the care of selected palliative care patients with otherwise refractory distress.

[T]he level of sedation used should be the lowest necessary to provide adequate relief of suffering: “The doses of medications should be increased or reduced gradually to a level at which suffering is palliated with a minimum suppression of the consciousness levels and undesirable effects, with documentation of the reason for changes and response to such manoeuvres.” Only under exceptional circumstances is deep and continuous sedation required from initiation of palliative sedation therapy.

Having misleadingly claimed that palliative care experts concede that pain and other physical symptoms cannot be alleviated and that therefore some Victorians are faced

¹ http://www.parliament.vic.gov.au/images/stories/committees/SCLSI/EOL_Report/LSIC_58-05_Text_WEB.pdf

² http://www.parliament.vic.gov.au/images/stories/committees/lsic/Submissions/Submission_236_-_Palliative_Care_Victoria.pdf

with unavoidably painful deaths the End of Life Choices majority report then niftily substituted a **purely subjective notion of suffering** for that of objective pain and other physical symptoms.

Assisted suicide in Oregon: *not* for pain

"Enduring and unbearable suffering" is a phrase capable of including the [prime reasons given by the 1275 people who have died under Oregon's assisted suicide law](#):

- A steady loss of autonomy (90.9%)
- Less able to engage in activities making life enjoyable (89.5%)
- Loss of dignity (75.7%)
- Loss of control of bodily functions, such as incontinence and vomiting (45.7%)
- Physical or emotional burden on family, friends, or caregivers (43.7%)³

Only 327 out of 1275 people (25.8%) mentioned inadequate pain control or concern about it. [Earlier annual reports noted that "Patients discussing concern about inadequate pain control with their physicians were not necessarily experiencing pain."](#)⁴

In [2017](#) just over one in five (21%) mentioned concern about inadequate pain control but more than half (55.25%) cited concerns about being a burden on others as a reason for seeking assisted suicide.⁵

Ian Haines: a change of mind on euthanasia



Associate Professor Ian Haines, MBBS is a medical oncologist and palliative medicine specialist. He [comments](#):

As an oncologist with 35 years' full-time experience, I have seen palliative care reach the point where the terminally ill can die with equal or more dignity than euthanasia will provide. It is now very effective and increasingly available for two of the three possible ways of dying, outside of sudden unexpected death, which are advanced cancer and chronic relapsing and remitting organ-specific disease such as heart or lung failure.

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<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf>

4

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year6.pdf>

5

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf>

Palliative care is also available for people with chronic progressive cognitive diseases such as dementia. This is the fourth way of dying and perhaps the most feared of all.

Like Andrew Denton and others who have observed unbearable suffering in loved ones and the terrible failures of modern medicine in the past, I had once believed that euthanasia was the only humane solution.

I no longer believe that.

If the Victorian government legalises assisted dying for people suffering from serious and incurable conditions, it will be the wrong choice. It is not necessary and, as outlined in the minority report to government, it will inevitably increase the pressure, both stated and perceived, for some chronically ill patients to move on and stop being a burden.⁶

Australian Pain Management Association

The [Australian Pain Management Association](#) is concerned legalising assisted suicide "may lead to government having an opportunity for people to end their life with the help of another person rather than investing in early pain management support and the medical treatment and community support that people need in order to have a 'good death' and die with dignity".

"Australia has achieved a high level of expertise in pain and palliative medicine including well-coordinated multidisciplinary care. However, this needs to be delivered across the health care system, particularly at home or in residential aged care facilities. Less than optimal analgesia and symptom control are major obstacles to quality end-of-life care.

"[E]ndorsing such a Bill [may] let health services off the hook from providing the best and widest pain management services."⁷

Conclusion

No case for legalising assisted suicide can properly be made on the basis that this is the only possible response to people facing unrelievable pain.

Every Australian deserves access to gold standard palliative care which can alleviate pain, including using palliative sedation as a last resort.

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<http://www.theage.com.au/comment/i-believed-that-euthanasia-was-the-only-humane-solution-i-no-longer-believe-that-20161118-gss921.html>

⁷ <https://www.painmanagement.org.au/>