

Assisted suicide & “severe pain and suffering”: What are the facts?

The draft proposition to soon be introduced into the NSW Parliament is to legalise assisted suicide for persons who are ‘experiencing severe pain, suffering or physical incapacity to the extent unacceptable to the patient’.

But, is this really all about severe pain and suffering?

ASSISTED SUICIDE IN OREGON: NOT FOR PAIN

“Severe pain and suffering” is a phrase capable of including the prime reasons given by the 1127 people who have died under Oregon’s assisted suicide law:

- A steady loss of autonomy (91.4%)
- Less able to engage in activities making life enjoyable (89.7%)
- Loss of dignity (77%)
- Loss of control of bodily functions, such as incontinence and vomiting (46.8%)
- Physical or emotional burden on family, friends, or caregivers (42.2%)

Only 296 out of 1127 people (26.3%) mentioned inadequate pain control **or concern about it**.¹ Earlier annual reports noted that “Patients discussing concern about inadequate pain control with their physicians were not necessarily experiencing pain.”²

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.

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.*³

If the Parliament of New South Wales legalises assisted dying for people suffering from severe pain and suffering, it will be the wrong choice. It is not necessary and it will inevitably increase the pressure, both stated and perceived, for some chronically ill patients to move on and stop being a burden.

PALLIATIVE CARE: PAIN CAN BE ALLEVIATED

The Palliative Care Victoria submission to the Victorian Inquiry⁴ 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.

AUSTRALIAN PAIN MANAGEMENT ASSOCIATION

The Australian Pain Management Association is concerned that the proposed assisted suicide Bill “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.”⁵

A NOTE ON ‘PHYSICAL INCAPACITY’

As the data from Oregon shows, physical incapacity is a genuine concern.

However, the ability to seek assisted suicide because of such incapacity – or even simply the fear of such incapacity – is something that is of deep concern to the disability community.

It is a negative trope that diminished the worth of people with disabilities – particularly degenerative ones – because what they see is: ‘They don’t want to be like us.’

CONCLUSION

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

The people of NSW need universal access to gold standard palliative care which can alleviate pain, including using palliative sedation as a last resort.

The actual proposal for legalising assisted suicide would cover subjective, existential suffering, including fear of being a burden on others.

Legalising assisted suicide for these reasons is not safe.

¹ Oregon Public Health Division, *Oregon Death With Dignity Act: Data Summary 2016, Table 1. Characteristics and end-of-life care of 1,127 DWDA patients who have died from ingesting a lethal dose of medication as of January 23, 2016 [sic = 2017], by year, Oregon, 1998-2016*, p.10, <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf>

² Oregon Health Authority, *Sixth Annual report on Oregon’s Death With Dignity Act*, 2004, p. 24 <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year6.pdf>

³ Ian Haines “I believed that euthanasia was the only humane solution. I no longer believe that.”, *Sydney Morning Herald*, 20 Nov, 2016, <http://www.smh.com.au/comment/i-believed-that-euthanasia-was-the-only-humane-solution-i-no-longer-believe-that-20161118-gss921.html>

⁴ http://www.parliament.vic.gov.au/images/stories/committees/lpic/Submissions/Submission_236_-_Palliative_Care_Victoria.pdf

⁵ Elizabeth Carrigan, Chief Executive Officer, Australian Pain Management Association Inc. (APMA), Correspondence, 24 Feb 2017

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