



LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON END OF LIFE CHOICES IN THE ACT

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Submission Cover Sheet

End of Life Choices in the ACT

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Submission to

The Select Committee in respect of its

Inquiry into End of Life Choices in the ACT

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Summary

This submission intends to address the following Terms of Reference particularly:

- current practices utilised in the medical community to assist a person to exercise their preference in managing the end of their life, including palliative care
- ACT community views on the desirability of voluntary assisted dying being legislated in the ACT;
- risks to individuals and the community associated with voluntary assisted dying and whether and how these can be managed;

Firstly, the title of the Inquiry chooses language indicative of a particular attitude to the matter under consideration. That is, ‘end of life choices’ is one among other euphemistic phrases such as ‘giving people choice’, ‘providing death with dignity’, and ‘taking control of dying’. All such expressions are, deliberately or not, frequently code for legalising the choice of euthanasia, or expressed more benignly, voluntary euthanasia/assisted suicide. While death is inevitable for everyone, the ethical question to be addressed is the way in which we die. Suicide is legal in Australia, but a personal and social tragedy nonetheless.

Euthanasia is a threat to the most vulnerable members in our society: the frail, the handicapped, the very old and those suffering mental illness, especially dementia. Philip Nitschke, the most passionate advocate of euthanasia, has admitted that the persons he killed under the short-lived Northern Territory legalised euthanasia regime suffered more from fatigue, frailty, and depression than from pain or suffering arising from their condition. In the Netherlands and Belgium where euthanasia is legal the categories of persons ‘eligible’ for death by lethal injection is ever-expanding even to include young children and those ‘weary of life’.

While admittedly the current position is that the ACT does not, under the provisions of the *Euthanasia Laws Act 1996* (Cth), have the power to legalise euthanasia, it is not only premature but poor public policy for the ACT Government to be considering a legislative framework which would facilitate the deliberate taking of life. Though such changes often soften their true impact by characterising them, as set down in the Terms of Reference’, as ‘voluntary assisted dying’, careful consideration would conclude that such ‘assistance’ is nothing more than euthanasia. Euthanasia is the correct term for any legislative provisions which provide for deliberate killing with or without a person’s consent and regardless of whether the affected person is killed by another person or is provided with the means of killing him/herself.

The ACT, along with the Commonwealth and other Australian Governments, has made serious commitments over the past decade to promote and fund health programs which include the prevention of, or at least a reduction in the rate of suicide. Tragically, suicide accounts for a large proportion of all deaths among young adults and other significantly vulnerable persons, such as those of indigenous background, men generally particularly those in rural areas, and persons suffering from mental illness including depression.

Legalised euthanasia would not be in the best interests of either the ACT or the Australian community as a whole. The ACT occupies a significant position in the Australian social and political psyche as the home of our Federal Parliament. Legalising direct killing of persons by medical staff or any other person would set a persuasive example, possibly more influential than legislation in any other Australian jurisdiction, and encourage urging by euthanasia advocates/publicists that the rest of Australia should follow.

Further, the enactment of such socially and morally significant provisions in the ACT would not be in the best interests for the practice of medicine and other health services. Inevitably the ACT would house a specialist outlet(s) where the 'business' would not be expert diagnosis of a patient's condition nor referral to palliative care facilities, but rather death delivered as requested. It is a fact that experience in countries where euthanasia is legal, such as the Netherlands and Belgium, 'voluntary euthanasia' has led to the practice of involuntary euthanasia for those persons deemed incompetent to make a choice for themselves.

Such an approach is in stark contrast to a principle which holds that vulnerable persons such as the depressed, those with physical or mentally disabilities, the frail aged and the dying should be given every assistance to cope with their situation without deliberate intervention causing death. It would not enhance the reputation of the ACT to become a euthanasia haven for those interstate patients who are experiencing difficulty in the management of their illness or those simply whose condition makes a bleak prospect of their lives. The better course would be to set a national benchmark for the provision of expert palliative care services.

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I. Suicide in Australia

In 2016, 2,866 people died from intentional self-harm. The standardised death rate was 11.7 deaths per 100,000 people, the third highest rate recorded in the past 10 years. It represents an increase compared to the rate of 10.6 suicide deaths per 100,000 people in 2007.

Comparison of male and female suicide rates

Deaths from intentional self-harm occur among males at a rate three times greater than that for females. In 2016, the standardised death rate for males was 17.8 deaths per 100,000 people, while for females it was 5.8 deaths per 100,000 people.¹

The highest proportion of suicide deaths of males occurs among those aged 30-34 years. For females, the highest proportion of suicide deaths occurs in those aged 50-54 years, which is also the age group at which the sex difference in proportion of suicide deaths is most apparent. For both males and females the proportion of deaths due to suicide decreases among those aged 55 years or more.

Suicide as a proportion of total deaths

While intentional self-harm accounts overall for 1.8% of all deaths in Australia, it accounts for a higher proportion of deaths among younger people.²

In 2016, suicide was the leading cause of death among all people 15-44 years of age, and the second leading cause of death among those 45-54 years of age, accounting for over one-third of deaths (35.4%) among people 15-24 years of age, and over a quarter of deaths (28.6%) among those 25-34 years of age. For those people 35-44 years of age, 16.0% of deaths were due to intentional self-harm. The median age at death for suicide was 43.3 years. This compares to a median age of 81.9 years for all deaths.

II. Suicide and public health policy – approach of Australian Governments

“Voluntary euthanasia’ is simply assisted suicide, a doctor usually the intended deliverer of the assistance. In light of the Commonwealth’s and the States’ long-standing interest in, and active support of efforts to prevent suicide, it would be perverse for any Australian parliament to pass a measure facilitating assisted suicide.

In 2004 the Commonwealth established the *New National Advisory Council on Suicide Prevention*³; and subsequently in 2005 amended the Criminal Code Act 1995 (Cth) to include sections 474.29A and 474.29B, making it an offence to transmit, through telephone or internet, suicide related material with the intention, directly or indirectly, of counselling or inciting a person to commit or attempt to commit suicide.

¹ Australian Bureau of Statistics, *Suicides, Australia, 2010* (cat. no. 3309.0, Table 3.1). The data on suicide in this publication is sourced from the ABS Causes of Death, Australia, 2010 (cat. no. 3303).

² House of Representatives Standing Committee on Health and Ageing. Canberra July 2011 Canberra.. *Report on early intervention programs aimed at preventing youth suicide.*

³ *A Contributing Life: 2012* (National Report Card on Mental Health and Suicide Prevention) p.6.

In considering the provisions of the *Criminal Code Amendment (Suicide Related Material Offences) Act 2005* the Senate Legal and Constitutional Affairs Committee called for the implementation of additional broader research, strategies, resourcing and policy initiatives by the Federal Government **and State/Territory governments in order to address jointly and consistently issues relating to suicide in Australia** (Recommendation 4). [bold added]

In July 2006, the Council of Australian Governments agreed, through the *National Action Plan on Mental Health 2006 – 2011*, to improve mental health services through promotion and prevention programmes, including suicide prevention.

In June 2010 the *Senate Community Affairs References Committee's Report: The Hidden Toll: Suicide in Australia* recommended an economic assessment of the cost of suicide and attempted suicide in Australia and the development of a national suicide prevention and awareness campaign. The campaign was to include a targeted approach to high-risk groups, in particular young people, persons in rural and remote areas, men, and indigenous populations. Through cooperation with business and community groups the aim was to reduce the suicide rate by 2020.

In 2012 the Australian Government responded to the Senate Report, agreeing to support measures to reduce the damage suicide causes, noting that more than 2000 Australians take their lives every year – a tragedy for individuals, for families, for communities and for the whole nation. Acknowledging that the causes of suicide are numerous, issues such as isolation, disengagement, or instability in employment, housing, financial stress or personal relationships, the Australian Government increased funding of the *National Suicide Prevention Strategy* (NSPS) from \$8.6 million in 2005–06 to \$23.8 million in 2010–11.

Before the 2010 election the Prime Minister, the Hon Julia Gillard MP, committed the Australian Government to redouble its efforts to prevent the tragedy of suicide, making clear that mental health was an important part of her Government's second term agenda and announcing a \$274 million *Mental Health: Taking Action to Tackle Suicide* package, in an agreement with **State, Territory and local governments to set a target to reduce the suicide rate by the year 2020**. [bold added]

The opening words of the House of Representatives Standing Committee on Health and Ageing in 2011 are worth quoting:

“Every year in Australia suicide claims the lives of around 2000 Australians placing it ahead of road traffic accidents and skin cancer as a cause of death. For young people aged 15 to 24, it is the number one cause of death. New, strong and ever growing community engagement with these issues now place **mental health and suicide prevention firmly on the national policy agenda for political parties** (Foreword: Report on early intervention programs aimed at preventing youth suicide).⁴ [bold added]

⁴ House of Representatives Standing Committee on Health and Ageing. Canberra July 2011 Canberra.. *Report on early intervention programs aimed at preventing youth suicide*.

The 2012 Report of the Australian Government National Mental Health Commission stated:

“[E]ven the most disadvantaged should be able to lead a contributing life. ... enriched with close connections to family and friends, good health and wellbeing to allow those connections to be enjoyed, having something to do each day that provides meaning and purpose”.⁵

Noting estimates of over 65,000 reported suicide attempts in Australia each year, the Commission recommended a coordinated effort to “prevent and reduce suicides, and support those who attempt suicide through timely local responses and reporting”.

With access to the promotion of suicide through the internet now restricted by the provisions of that legislation, it would be regrettable if the law of the ACT were to assist facilitation of assisted suicide. To do so would be poor public policy and undermine the ethical foundations of Australia’s health services.

Former Prime Minister Julia Gillard has continued her dedicated involvement in addressing mental issues and, in her role of Chair of beyondblue, continues to target Australia’s high suicide rate.

Again, a new evidence-based systems approach to suicide prevention has been rolled out in communities across New South Wales. Developed by researchers at the Black Dog Institute and the NHMRC Centre for Research Excellence in Suicide Prevention to address high national suicide rates, LifeSpan is intended to significantly reduce suicide deaths and attempts. The approach consists of nine strategies that are meant to be implemented simultaneously and tailored to the local context, including: 1) aftercare and crisis care for suicide attempt survivors, 2) psychosocial and pharmacotherapy treatment, 3) training and support for general practitioners, 4) frontline training for ambulance and emergency department workers, 5) gatekeeper training for educators, social workers, and religious leaders, 6) school-based educational programs, 7) community awareness campaigns, 8) media reporting recommendations, and 9) means restriction.

III. Suicide and the law

Legislators have a responsibility to protect the community and govern for the common good, even if this involves some interference in the interests of some persons, specifically in this context to restrict a demand by some persons to involve others in their death. Moreover, the whole community has a responsibility to protect vulnerable people and to provide the best medical and social care.

The law also has an educative dimension. For this reason aiding or abetting a suicide has, until the passing of the *Voluntary Assisted Dying Act 2017* (Vic.), remained illegal in Australia. As the Victorian provisions do not come into effect fully until 2019 it is impossible to comment on outcomes. A number of organisations and individuals argue that, as suicide is no longer a crime, providing information to assist suicide and actively assisting persons to commit suicide should be lawful. But just because suicide is not a crime does not mean it should be promoted or facilitated. Suicide was decriminalised because there was little value in prosecuting someone who was dead or who had attempted suicide.

⁵ *A Contributing Life: 2012* (National Report Card on Mental Health and Suicide Prevention), page 6.

IV. Legalised euthanasia in the Northern Territory –and the accompanying practice of euthanasia

Advocacy for legalising euthanasia/ assisted suicide cannot be satisfactorily discussed without reference to the work and views of Dr Philip Nitschke, Australia's leading advocate of euthanasia. Dr Nitschke has maintained defence of his role in the operation of the short-lived *Rights of the Terminally Act 1995* (NT) (the ROTI Act).⁶ He falsely claimed that applicants to be killed were assessed according to strict criteria and only 4 of 7 persons met these criteria.⁷ In fact, all 7 applicants for euthanasia were deemed to meet the criteria; only four were killed during the period of operation of the ROTI Act as reported in *The Lancet*, a leading UK medical journal. This paper notes the “clear limitations of the gate-keeping roles of the medical specialist and psychiatrist in the ROTI legislation”. The article records that:

Depression was a major factor in the Northern Territory's experiment with euthanasia. ... Of seven cases studied, Case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management.⁸

The authors also admit that fatigue, frailty, depression and other symptoms contributed more to the suffering of the patients than any pain arising from their condition; yet these persons met the requirements of the then Northern Territory euthanasia law.

This analysis of the management of euthanasia in the first enabling Australian legislation gives warning that, despite any apparently strict criteria of eligibility for being killed (by lethal injection in the case of the ROTI Act), provides compelling evidence of the extension of eligibility to include the depressed of any age, the aged frail, the physically handicapped or mentally ill, patients in coma, etc.

Pro-euthanasia groups cannot dissociate themselves from the activities of Dr Nitschke's high-profile advocacy of euthanasia and suicide. He has said that knowledge of suicide methods should be available to anyone who wants it “including the depressed, the elderly bereaved, [and] the troubled teen”.⁹ Further, the suicide pill “should be available in the supermarket so that those old enough to understand death could obtain death peacefully at the time of their choosing”.¹⁰

Nitschke's manifesto, has pointed to the economic benefits of euthanasia. Noting that end-of-life care is expensive, he has said that ‘voluntary euthanasia’ could lop a mere six months off the lives of ailing elderly, immense savings to government budgets:

One can but wonder when a government will have the guts to stop digging the fiscal black hole that is their ever-deepening legacy for future generations. While the enabling of end-of-life choices will not fix the economic woes of the next 40 years, it would not hurt, given half a chance. So the next time you hear a government minister trying to argue why this or that payment or welfare program for single mothers or war veterans must be cut, counter their argument with their fiscal irresponsibility on end-of-life choices.¹¹

⁶ The ROTI Act was quashed by Federal Parliament in 1996.

⁷ *Canberra Times* 4 February 2011, p10.

⁸ Kissane, D, Street, A, Nitschke, P (1998), Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia. *The Lancet*, Vol 352, pp1097-1102.

⁹ US Online review 5 June 2001: An interview with Philip Nitschke, the other “Dr.Death”.

¹⁰ *Ibid.*

¹¹ *Ibid.*

Dr Nitschke also included prisoners among the potential beneficiaries, mooted voluntary euthanasia as "the last frontier in prison reform".¹²

Therefore the persistent campaign in all Australian States for the legalisation of euthanasia cannot be separated from the views of its chief advocate, architect and practitioner, Dr Nitschke who over many years has been providing assistance, advice and materials to assist persons achieve that end. Notably he has keenly supported various Bills in the Federal Parliament advocating a return to the ACT and NT the power to legislate for euthanasia, specifically flagging that legalisation of euthanasia in the ACAT would "put immense pressure on [the] States". Nitschke himself has sought election in the NT as a Greens candidate. Beginning in 2007 the then Greens leader Senator Brown introduced a number of Bills seeking to return the power of legislating for euthanasia to the Australian Territories; others have taken up the baton.

Dr Nitschke's activities in particular and the recent, untested Victorian legislation legalising voluntary euthanasia, that is assisted suicide, stand in stark contrast to Australia's national strategy to reduce the suicide rate.

V. The effects of euthanasia/assisted suicide on medical practice

Further, legal euthanasia would not be in the best interests for the practice of medicine and related health services. Inevitably 'specialist' outlets would develop where the 'business' would not be expert diagnosis of patients' health nor referral to palliative care facilities, but delivery of death. In particular it would be a tragedy to have euthanasia legalised in the ACT which would likely become the 'death-tourism capital' of Australia.

Although euthanasia is legal in the Netherlands, some Dutch pharmacists are refusing to supply the lethal drugs needed to carry it out. According to the investigative TV program *Altijd Wat Monitor*, this does not necessarily happen because of religious objections to euthanasia. Some pharmacists do not know the doctors who approved the euthanasia; others do not agree with euthanasia for conditions like dementia or depression. "A pharmacy is not a shop where deadly drugs are just handed over," a spokesperson for the pharmacists' association said.

Of interest was the reported reaction of Dutch Green MP Linda Voortman who expressed outrage at the news and wanted the Health Minister to intervene. "Pharmacists should not be able to refuse what two doctors have approved," she said.

Compassion in the eyes of some inevitably becomes coercion in the hands of others.

It is significant that in the lead-up to the passing of the euthanasia-enabling Victorian legislation both the Australian Medical Association and its Victorian Branch along with organisations representing nurses and other health workers opposed the legislation; concern was expressed that such legislation would have a deleterious effect on the practice of their caring professions.

¹² Nitschke, P., *Killing Me Softly: Voluntary Euthanasia and the Road to the Peaceful Pill*. Penguin Books 2005.

VI. Palliative care

If doctors were to actively assist patients to kill themselves, then another significant barrier to the acceptability of suicide would be removed. Consequently the role of, and provision for palliative care services would likely be reduced; euthanasia and assisted suicide have no appropriate place within the practice of true palliative care. Palliative Care, as defined by the World Health Organisation, 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 nor postpone death;
- integrates the psychological and spiritual aspects of patient care ...”

Two key principles underline the difference between palliative care and euthanasia/assisted suicide; the former:

- affirms life and regards dying as a normal process; and
- intends neither to hasten nor postpone death.

Nonetheless, supporters of morally ethical palliative care recognise that when a person is dying there is no obligation to seek to prolong that person’s life by extraordinary medical interventions, nor to use supportive means that are unduly burdensome.

It is therefore of concern that many commentators are ill-informed about the operation of the principle of “double effect” in medical practice. This principle refers to a non-uncommon medical situation where an action is undertaken (or not undertaken) as part of ethical palliative care practice, but which may also have the indirect effect of hastening the patient’s death. Examples include: the withdrawal of corticosteroids when they are no longer controlling brain swelling and further prescribing would be futile; or an increase in the dosage of a medical opioid in order to try and control increasing pain. In such cases the actions are not undertaken deliberately to hasten a patient’s death; they may, however, coincide with, or indirectly hasten a patient’s death.

Palliative care cannot prevent all unpleasant symptoms in the end of life stage. Its practitioners certainly seek to control and prevent any pain that patients are experiencing. Australia is among the leading countries in researching new palliative care medications for both adult and paediatric palliative care. Much more, however, could be done by State, Territory, and Commonwealth Governments to ensure that such services are broadly available to rural as well as urban patients.

An investigation by the Victorian Auditor-General found that 67 per cent of people who died in 2012–13 while in the care of a Victorian community palliative care service recorded their preferred place of death. While most indicated they would prefer to die at home - a much cheaper option than hospital care - only half were able to do so. Further, dying people in Victoria face waiting lists of up to six weeks for specialist care to relieve pain and suffering.¹³

The Auditor-General's Report (the Report) said:

[t]his remains a major concern for metropolitan inpatient facilities wishing to discharge patients to the community. It could potentially result in patients staying in hospital longer than they want, or receiving basic, non-palliative care in the home, or even re-presenting to hospital if symptoms escalate or become distressing,"

While the Department of Health and Services (DHHS) stepped in to provide alternative solutions, the Report said it was a "far from ideal set of circumstances". Auditor-General Doyle said: "[going] forward, it is imperative that DHHS sets clear expectations for service delivery across the state and provides sufficient and appropriate funding to health services and community organisations."

Further, the Report said uptake of advance care plans that outline people's preferences at the end of life had been slow and that not enough health professionals were initiating conversations about death with patients. It said the plans were being used by around half of all patients supported by community palliative care services; this figure that had not changed over a considerable period of time.

About 36 000 people die in Victoria each year and this figure is projected to double in the next 25 years. The Report said palliative care aims to improve the quality of life of people with terminal illnesses by managing pain and distressing symptoms, and assisting patients to start making choices about how they want to be cared for as they die.

Palliative Care Victoria has called for an extra \$10 million to be invested in services. In its submission to the parliamentary committee on the euthanasia Bill the organisation, pointing to the legislation's defects, said an estimated 10,000 Victorians died every year – one in four deaths – without access to palliative care. Further, (PCV) argued that the Bill failed to provide adequate protection for vulnerable persons. Chair of PCV, Michael Bramwell, said he was pleased the Auditor-General's Report had highlighted the need to improve community awareness of palliative care and the need for more support for carers.

¹³ Victorian Auditor-General's Report tabled 15 April 2015,

VII. Vulnerable persons

In 2016, 2,866 people died from intentional self-harm. The standardised death rate was 11.7 deaths per 100,000 people.¹⁴ That is more in excess of the annual road toll in excess of 1500 deaths per year that we see regularly reported on the television news.¹⁵ A study by the World Health Organisation (WHO) found that, despite there being almost one million suicides every year, suicide is a largely preventable public health problem if the right policies and interventions are in place.¹⁶

Unfortunately, however, a significant pool of young people commits to either suicide or self-harm. Some 7%-14% of adolescents will self-harm at some time in their life, and 20%-45% of older adolescents report having had suicidal thoughts at some time. Certainly there is a very high association between suicide in adolescents and depression. Psychological post-mortem studies of suicides show that a psychiatric disorder (usually depression, rarely psychosis) is present at the time of death in most adolescents who die by suicide.¹⁷

Significant risk factors overall for suicides are major depression, substance abuse, severe personality disorders, male gender, older age, living alone, physical illness, and previous suicide attempts. For terminally ill patients with cancer and AIDS, several additional risk factors are also present.¹⁸ Given the high association between depression, a treatable condition, and being suicidal, it is important that depression is always considered when suicide is discussed. Depression is often missed or not treated properly.¹⁹

Depression is more difficult to detect than many other health conditions because those suffering the condition are often unaware of their illness:

Unfortunately, because a common symptom of depression is a loss of insight and a feeling of hopelessness, depressed people usually have little understanding of the severity of their illness. They are often the last to recognise their problem and seek help. It is therefore critical that primary care physicians develop the skills to recognise depression in patients, particularly the terminally ill and elderly, whose depressive symptoms may be masked by coexisting medical conditions such as dementia and coronary artery disease.²⁰

Depression was a major factor in the Northern Territory's experiment with euthanasia, as it is a major factor in the problem of suicide. In a major review of the case notes of seven people who sought euthanasia in the Northern Territory there was evidence of inadequate consideration of depression:

To what extent was the psychiatrist trusted with important data and able to build an appropriate alliance that permitted a genuine understanding of a patient's plight? In case 1, there was

¹⁴ See footnote 1.

¹⁵ Australian Transport Safety Bureau (2005), Road Deaths Australia: Monthly Bulletin January.

¹⁶ Suicide huge but preventable public health problem, says WHO.. Media release for World Suicide Prevention Day - 10 September. World Health Organisation. Issued 8 September 2004.

¹⁷ Hawton, K and James, A (2005) Suicide and deliberate self harm in young people. *British Medical Journal*, Vol. 330, pp 891-894.

¹⁸ New York State Taskforce on Life and the Law (1994), page 12.

¹⁹ Hitchcock Noel, P et al (2004), Depression and comorbid illness in elderly primary care patients: impact on multiple domains of health status and well-being. *Annals of Family Medicine*, Vol 2(6), pp 555-562.

²⁰ New York State Taskforce on Life and the Law (1994), When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context. New York State Department of Health, page 15.

important background detail about the death of one child and alienation from another, which was withheld during the psychiatric assessment. These experiences may have placed the patient in a lonely, grieving, demoralised position: an unrecognised depression may have led to suicide.

Four of the seven cases had symptoms of depression, including reduced reactivity, lowered mood, hopelessness, and suicidal thoughts. Case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management. [Philip Nitschke] judged this patient as unlikely to respond to further treatment. Nonetheless, continued psychiatric care appeared warranted.²¹

Despite the importance of depression in contributing to suicidal behaviour, it has been reported that Exit International's director Dr Philip Nitschke, despite the circumstances of the operation of the ROTI (NT) legislation, maintains that it is unnecessary to seek expert opinion on whether those who approach him are suffering from depression, saying:

I would say common sense is a good enough indicator. It's not that hard to work out whether you are dealing with a person who is able to make rational decisions or not.²²

Such an attitude demonstrates ideologically driven resistance to what is known of depression. Such vulnerable young people could be pushed over the edge to their death by individuals or groups promoting suicide or legislation which provides for death to be delivered by the provision of lethal means to be either self-administered or delivered by medical staff.

An extract from an article published in the *Canadian Medical Association Journal* evidences the extension of grounds for permitting euthanasia and the effect on vulnerable persons.²³

The evidence is clear that where assisted suicide or euthanasia is legalised there are serious concerns over how legally permitted assisted suicide is applied. In addition, Dutch pro-euthanasia groups are campaigning to further extend grounds for assisted suicide eg to people with dementia. In 2010 the Dutch parliament was to debate a measure to legalise euthanasia or assisted suicide for anyone over 70 who had "simply had enough of life".²⁴ It is hardly necessary to point out the dangers of such proposals where the target population might include widows and widowers overwhelmed by grief, those unwilling to face the frailties of extreme old age and so on. Here is also the danger of older persons being pressured to end their lives to the advantage of their beneficiaries. It is perfectly credible that reports of elderly people in the Netherland are so fearful of being killed by doctors that they carry cards saying that they do not want euthanasia.²⁵

Legislators should not compound the suffering of victims of physical or mental illness and of their families by encouraging suicide rather than providing the help they obviously need.

If it becomes routine to ask for assistance to die, then this acceptance becomes a pressure on people to end their lives with the self-justification that they will ease the burden on family while ending their own physical and psychological pain. Fear of dependency and reluctance to burden family members are influential factors in making a decision to commit suicide.²⁶

²¹ See footnote 10.

²² Pelly, M, A better option: the wait for a way out. *The Sydney Morning Herald*, March 19 2005.

²³ Chambaere, K. et al., *Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey*. *Canadian Medical Association Journal* June 15, 2010 vol,182 no.9.

²⁴ *Daily Mail.co.uk* by Mail Foreign Service. 10 March 2010.

²⁵ *Telegraph*, United Kingdom, 22 April 2011.

²⁶ Johnson, T (2003), Book review: Suicide and euthanasia in older adults: a transcultural journey. *Psychiatric Services*, Vol 54, pp 261.

Euthanasia is not a civilised solution to illness, pain or depression. There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care. Persons who are clinically depressed may wrongly see themselves as terminally ill. To allow such persons to seek death undermines the protection of the law for vulnerable suicidal people. Legal euthanasia signals that sometimes people's lives are no longer of value and can rationally be extinguished with assistance - a dangerous notion.

A Church of England cleric wrote recently in the (UK) *Guardian* that the romanticisation of suicide in earlier times has been replaced by the equally unfortunate current tendency to over-expose 'celebrity suicide'. There was nothing glamorous about taking one's own life, wrote Father Giles Fraser of St Mary's Newington in south London, giving this advice:

"... If suicide is on your mind, forget the existentialists and the poets. Phone a helpline. Go and see your GP. Talk to friends. Stop drinking. Misery is survivable. And hold fast to the belief that a brighter day will dawn."

This is the reasonable and compassionate response to a person's demand for assistance in committing suicide.

The Australian experience with euthanasia shows that the significance of depression and psychiatric illness in euthanasia and by implication in suicidal people should not be underestimated. Legalising assisted suicide will not promote understanding of, nor improve the management of depressed persons.

Finally, it is futile to think that 'end of life choices' are necessarily confined to the dying and/or elderly. The experience of pain and feelings of despair are experienced by all age groups and in the contest of both physical and mental illness. Once any persons are eligible for assisted death, then the categories of eligible 'sufferers' will inevitable expand to the great detriment of all, especially the young and the mentally ill.

VIII. Legal euthanasia - the Netherlands, Belgium & Switzerland

The Netherlands

Official government reports, the *Remmelink Report* (1991), the *Van der Maas Report* (1995) and the *Onwuteaka-Philipsen Report* (2001), provide very detailed data regarding the practice of euthanasia in the Netherlands. The overall conclusion was that physicians intentionally kill approximately 1000 patients each year without each patient's request or consent, representing between 0.7-0.8 percent of all deaths in the Netherlands. In slightly less than half of all involuntary euthanasia cases, the patient had not discussed euthanasia with the physician nor expressed a wish to be relieved of suffering. Significantly, in 79 per cent of these cases, the patient was mentally incompetent. The *Remmelink Report* also revealed that slightly less than 5,000 patients were killed each year by terminal sedation without explicit request; some of these deaths were deemed likely to be instances of involuntary euthanasia.²⁷ Overall one in every 32 deaths in the Netherlands resulted from legal or illegal euthanasia.

A study of euthanasia deaths in the Netherlands from 1990 to 2010 based on the death registry of *Statistics Netherlands* found that in 2010 there were 294 deaths recorded resulting

²⁷ Report of the Committee to investigate Medical Practice Concerning Euthanasia. *Medical decisions about the End of Life*. The Hague: Ministry of Justice and Ministry of Welfare, Public health and Culture 1991.

from euthanasia (2.8% of all deaths), a rate higher than the 1.7% in 2005. Though ending of life without explicit patient request, was slightly less than those reported in 2005, continuous deep sedation, continuous deep sedation until death occurred more frequently in 2010 (12.3%-789 deaths than in 2005 (8.2% - 521 deaths. It should be noted that only that in 2010 only 77% of these deaths due to euthanasia were reported to a review committee. Consequently adherence to the requirements of legislation cannot be confidently assessed.

Around 3.7% of deaths in the Netherlands in 2015 were due to euthanasia. The Netherlands' regional euthanasia review committees reported that there were 5,516 deaths due to euthanasia in 2015. That is out of a total of around 147,000 - 148,000 deaths in the Netherlands that year. This figure represents an increase of 4% of deaths due to euthanasia compared to 2014.²⁸

Reports from the Netherlands show that the consent of the patient is not always obtained, demonstrating that no matter how the legalising instrument is drafted 'voluntary euthanasia' inevitably develops into something else. Though consultation with a person wishing to be assisted to commit suicide is desirable, it proved not always the case in the Netherlands:

The physician also discussed the decision to perform euthanasia or assisted suicide with relatives of the patient in 75.5% of deaths in 2005 and with one or more colleagues in 87.7% of deaths. When life was ended without the explicit request of the patient, there been discussion about the act or a previous wish of the patient for the act in 60.0% of patients ... In 2005, the ending of life was not discussed with patients because they were unconscious (10.4%) or incompetent owing to young age (14.4%) or because of other factors (15.3%).²⁹

In the Netherlands a collection of 35 bioethics centres and institutions recently released a statement regarding the Dutch government's announcement that it would extend its euthanasia law to include children. While euthanasia has been openly practiced for two decades, it was only formalized in statute law in 2002. This law allows the killing of patients down to the age of 16; it is now proposed to lower the age to 12. Similar proposals are being considered in Belgium including the euthanasia of children without parental consent. Appeals have been made to the European Union to protect the basic human rights of children and newborns, where consent is not possible.³⁰

Belgium

A 2015 paper in the *New England Journal of Medicine* about euthanasia rates in the Flanders region of Belgium (the northern half of the country) noted that the rate of euthanasia increased significantly between 2007 and 2013, from 1.9% to 4.6% of deaths:

The key figures concerning **notifications received in 2016** are as follows.* In 2016, the RTE received 6,091 notifications of termination of life on request or assisted suicide. **This is 4% of the total number of people who died in the Netherlands in that year** (148,973). Of these

²⁸ *Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey.* [Onwuteaka-Philipsen BD¹, Brinkman-Stoppelenburg A, Penning C, de Jong-Krul GJ, van Delden JJ, van der Heide A.](#) *Lancet.* 2012 Sep 8;380(9845):908-15. doi: 10.1016/S0140-6736(12)61034-4. Epub 2012 Jul 11.

²⁹ Van der Heide, A. et al., *End-of-Life practices in the Netherlands under the Euthanasia Act.* *New England Journal of Medicine* 356; 19 May 10, 2007.

³⁰ *LifeIssues Newsletter* 2 221 April 2006. www.lifeissues.net

cases, 83% (5,077 cases) concerned patients with incurable cancer, neurological disorders (such as Parkinson's disease, multiple sclerosis and motor neurone disease), cardiovascular disease or pulmonary disease. Around **2% of the notifications concerned patients with dementia and around 1% concerned patients with a psychiatric disorder**. Some 4% of 52016 the notifications concerned patients with multiple geriatric syndromes. Again, the number of notifications rose in comparison with the previous year. In 2016 there were 575 more cases, many of which concerned patients with cancer, neurological disorders and cardiovascular disease. Compared to 2015, **there were also more notifications concerning patients with dementia (32 more), a psychiatric disorder (4 more) or multiple geriatric syndromes.**³¹ [bold added]

Although euthanasia has been legal in Belgium since 2002 critics have raised concerns in recent months about certain practices, including how quickly some doctors approve requests to die from psychiatric patients.

Evidence of gross negligence is mounting against Belgium's peak euthanasia regulatory body, the Federal Commission for Euthanasia Control and Evaluation. Dr. Ludo Van Opdenbosch, a neurologist who was a Commission member for several years, resigned in September 2017. Associated Press recently obtained the letter of resignation that Dr Van Opdenbosch sent to senior politicians, which details his dissatisfaction with the oversight processes of the Commission. "I do not want to be part of a committee that deliberately violates the law," he wrote. His resignation was prompted by his dissatisfaction with the Commission's failure to refer to authorities a doctor who allegedly euthanised a demented patient without consent; it was claimed that there was no record of any prior request for euthanasia from the patient.³²

Some experts say the case as documented in the letter amounts to murder; the patient lacked the mental capacity to ask for euthanasia and the request for the bedridden patient to be euthanized came from family members.³³

Subsequently more than 360 doctors, academics and others have signed a petition calling for tighter controls on euthanasia for psychiatric patients:

We call for tightening the criteria for euthanasia for psychological suffering and to all a commission to judge the case beforehand or preferably remove from the law unbearable and hopeless psychological suffering as a criterion for euthanasia. This would be a live-giving undertaking.³⁴

³¹ Regional Euthanasia Review Committees Annual Report 2016.

³² BioEdge bioethics news from around the world 19 February 2018.
<https://www.bioedge.org/bioethics/belgiums-euthanasia-commission-is-under-fire/12604>.

³³ <https://www.voanews.com/a/euthanasia-dispute-erupts-in-Belgium-over-euthanasia-rules/4258717.html>

³⁴ <https://www.rebelpsy.be> This website contains the statement of Belgian clinicians (psychiatrists, other doctors and psychologists) and academia about euthanasia in case of psychic suffering.

Switzerland

Lausanne University in Switzerland has announced that it will allow doctors and nurses, in that hospital, to kill patients. The hospital's legal director, Elberto Cresbo, stated "We are not trying to encourage suicide but, at the same time as a hospital, we have to respect the wishes of someone who wants to die."³⁵ The erosion of medical ethics seems to follow swiftly any legalisation of killing by doctors.

Thus experience in European countries illustrates this inevitable 'rationale' for extension of assisted suicide once it is legalised regardless of the 'safeguards' originally provided for in the enabling legislation.

IX. Assisted dying in Oregon (U.S.A.)

Many advocates of doctor-assisted suicide for terminally ill individuals claim that Oregon's law offers a suitable model. But there are serious problems with the Oregon legislation and many documented cases of abuse. Dr Aaron Kheriaty, associate professor of psychiatry and director of the Medical Ethics Program at the University of California Irvine School of Medicine, has treated thousands of patients who wanted to end their life; yet he writes that a request to die is nearly always a cry for help. In an extensive article in the *Mercury News* (California) he offered an analysis of the Oregon legislation. Among terminally ill individuals some 59 percent of cases suffer from depression. Yet, alarmingly, in Oregon less than 5 percent of individuals who have died by assisted suicide were ever referred for psychiatric consultation to rule out the most common causes of suicidal thinking. [Comment: this unfortunately echoes the Australian experience with the Northern Territory's short-lived ROTI legislation in 1995-6.]

Pressure from relatives in connection with financial considerations is a present danger. Dr Kheriaty reports that the Oregon Health Division has publicly stated that it has no resources and no authority to monitor or investigate reported cases of abuse.

Patients whose doctor refuses to assist in their death may be directed by their managed care insurance company to another doctor who will prescribe the lethal drug. In Oregon, a small number of physicians write a disproportionately large number of the prescriptions

Despite the inadequate system of monitoring and reporting in Oregon, the available data paints a distressing picture. After suicide rates had declined in the 1990s, they rose dramatically in Oregon between 2000 and 2010, in the years following the legalization of assisted suicide in 1997. By 2010, suicide rates were 35 percent higher in Oregon than the national average.³⁶

A rigorous study by David Albert Jones of Oxford University demonstrates that permissive assisted suicide laws have led to at least a 6 percent rise in overall suicide rates in Washington and Oregon.³⁷

³⁵ *The Guardian* 19 December 2006.

³⁶ The Mercury News . Oregon assisted suicide law no model for California by Professor. September 2, 2015 .

³⁷ *Euthanasia and Assisted Suicide: Lessons from Belgium* (Cambridge Bioethics and Law) 1st Edition by David Albert Jones (Editor), Chris Gastmans (Editor), Calum MacKellar (Editor)

X. Rejection of euthanasia by other countries

The overwhelming evidence accepted by parliamentary inquiries into euthanasia conducted in countries across the world is that it is dangerous to give someone the power to kill another person. Vulnerable people who are sick, aged or depressed are inevitably at risk of consenting to be killed rather than getting the help they need. In recent years legalisation of euthanasia or assisted suicide has been rejected in all major Western countries. On 21 April 2010 the Canadian Parliament rejected euthanasia Bill C-384 by 228 votes to 59.

On 1 December 2010 the Scottish Parliament threw out the *End of Life Assistance (Scotland) Bill*. Dr Gordon Macdonald commenting on this rejection commented:

The decision can be summed as a feeling that we have a duty to protect the wider public good from the demands of those who adhere to a radically self-focused view of personal autonomy. Hence many of the [Members of the Scottish Parliament] who voted against the Bill, although coming from no strong personal faith perspective, did so in good conscience because they felt that their primary duty was to protect the vulnerable from risk of exploitation and the pressure to end life prematurely as a result of feeling burdensome to family and friends.³⁸

The comprehensive House of Lords Select Committee on Medical Ethics consideration of assisted suicide published a number of reports in 2005 all of which rejected assisted suicide proposals.

In January 2011 the French Senate defeated a pro-euthanasia Bill by 170-142 votes. New Zealand rejected euthanasia by whatever description in August 2017.

XI. Euthanasia and the churches

Many church leaders have expressed their opposition to making assisted suicide legal. Such opinions deserve close consideration as church institutions have historically been in the forefront of providing care to the sick and the dying. For example, in their 2005 consultation Draft on *Advanced Care Planning* the Australian Catholic Bishops' Committee for Doctrine and Morals and Catholic Health Australia said:

- 1.2 Catholic ethical and social teachings seek to preserve respect for human dignity at all stages of life, particularly when people are most vulnerable due to illness or disability. In upholding respect for the worth and dignity of each person, we recognise the obligation that each of us has to take all reasonable measures to care for his or her own health, and so to use all "ordinary", reasonably available, and not overly burdensome, forms of effective medical treatment. (*Code of Ethical Standards for Catholic Health and Aged Care Services* [Catholic Health Australia, 2001], I, 1).
- 2.11 No one may rightly direct or ask that an unethical medical decision be made with respect to his or her care. Since euthanasia is wrong in itself, it would be wrong to request euthanasia, that is, to request that life-sustaining treatment be withheld or withdrawn *with the purpose of causing death*. In any case, euthanasia and assisted suicide are illegal in Australia.

³⁸ Dr Gordon Macdonald is Parliamentary Officer for CARE for Scotland and Policy Officer for *Care Not Killing Scotland*.

- 2.12 On the other hand: “Patients have the moral right to refuse any treatment which they judge to be futile, overly-burdensome or morally unacceptable, and such refusals must be respected” (*Code*, II, 1.16). When a treatment is withheld or withdrawn because it is futile or burdensome the intention is not to end life. Given the continuing debates over euthanasia and the withdrawal of medical treatment, it may be helpful for people reflecting on their future medical needs explicitly to state that they do want ordinary, life-sustaining treatment to be provided unless and until it becomes futile or overly burdensome.

The distinction between treatments intended to relieve pain and discomfort and deliberate action to take life is critical. The former is good medical practice and includes consideration for a patient’s choice to refuse any particular treatment; the latter is a denial of the medical principle of *Do No Harm* and makes the doctor an executioner.

In May 2006 moves to approve an assisted suicide proposal in Britain were strenuously opposed by the *Care Not Killing Alliance* which was formed by medical groups, organizations representing disabled people, and churches. Leaders of various faith groups wrote an open letter to all members of Parliament and the House of Lords. The groups, which ranged from Buddhists, Christians, Hindus and Jews, to Muslims and Sikhs, expressed their concern at the attempt to change the law and added that they held all human life to be sacred and worthy of the utmost respect.

Just prior to the parliamentary debate, Anglican Archbishop Rowan Williams of Canterbury, Cardinal Cormac Murphy-O’Connor of Westminster, and Chief Rabbi Jonathan Sacks wrote to British MPs, urging them to take steps to ensure adequate training is given to doctors and nurses to adequately treat such patients. They also asked that more centres of specialist palliative care be established. They noted that in countries where assisted suicide or euthanasia is legalized there are serious concerns over how it is applied.³⁹

The Lords voted 148-100 to postpone the debate. The British Medical Association continues to oppose assisted suicide or voluntary euthanasia.

XII. Legal euthanasia - a slippery slope?

It is too easy to disparage reasonable predictions of the consequences of certain laws and/or practices as a dubious ‘slippery slope’ argument. However the evidence is overwhelming that legal permission for doctors to directly kill patients with their permission has led to an indefensible extension of the concept of voluntariness. It is too readily argued that, if the competent are to exercise choice to relieve their distress, then why should the same freedom be denied to the incompetent? If distress or loss of will to live is appropriate for those who are elderly or afflicted with a terminal illness, why should relief be denied to the young and those suffering the burden of mental illness?

In 2001 Dr Nitschke said that he chose to restrict himself to helping the group of “terminally ill adults who are articulate, lucid and not suffering from clinically treatable depression”. However he signalled a shift in the same article. “Someone needs to provide this knowledge [of suicide methods], training or recourse necessary to anyone who wants (death), including the depressed, the elderly bereaved, [and] the troubled teen”.⁴⁰

³⁹ *The Times* 12 May 2006.

⁴⁰ Lopez, K J (2001), Euthanasia sets sail. *National Review Online*, 5 June.
<http://www.nationalreview.com/interrogatory/interrogatoryprint060501.html>

Following the quashing of the *Rights of the Terminally Ill Act 1995* (NT) Dr Nitschke became involved with highly publicised cases of suiciding persons who were not terminally ill. It began with Nancy Crick a resident of Queensland. After her suicide it emerged that Crick was not terminally ill. Suicide deaths of other persons in relatively good health followed. These actions were portrayed by the euthanasia lobby as rational suicides.

The concept of rational suicide greatly expands the range of people at risk from euthanasia activists who would appear to offer death as the easy solution rather than appropriate treatment and assistance. The difficult question of how to help suicidal people avoid a self-destructive course will be left unanswered. People at risk would include those living in social isolation, those with physical disabilities or even persons crushed by debt or bankruptcy.

A compelling legal analysis of developments following the legalisation of euthanasia in the Netherlands is provided in a paper demonstrating the inevitable slide from voluntary to involuntary euthanasia:

In December of 2004, administrators at a Dutch hospital announced a new policy that would allow pediatricians to kill severely handicapped newborn infants. In early 2005, the Royal Dutch Medical Association revealed that it had asked the government to propose new rules to facilitate the killing of "disabled children, the severely mentally retarded and patients in irreversible comas." To foreign observers who have not been following developments in the Netherlands, these news stories may have seemed shocking. Modern, liberal democracies are supposed to protect the mentally challenged and physically handicapped, not kill them.

For those who have been paying attention, however, these latest news reports merely represent the next logical step³ in the Netherlands' quixotic attempt to regulate euthanasia.⁴¹

XIII. Limits to the principle of personal autonomy

It is often asserted by pro-euthanasia advocates that to restrict access to assisted suicide is to place limits on a person's autonomy to take charge of their own lives. Autonomy of the individual, however, is not an absolute right. What may appear to be an exercise of choice in requesting assisted death is too frequently an indication that that the person may be suffering depression which can foment suicidal thoughts.

The exercise of one's person's autonomy, especially as approved by law, will increase pressure on the depressed, the frail, the elderly, and the confused to request euthanasia. People in those circumstances often feel they are a burden on relatives and consuming too much of society's resources. A law allowing euthanasia or assisted suicide, by legitimatising that option, removes the bulwark which should protect such persons from themselves and from those who might out of self-interest exploit their weakness.

During the debate on the Lord Joffe's 2006 UK euthanasia provisions Jane Campbell, a Disability Rights commissioner, explained how she suffers from a severe form of spinal muscular atrophy. "Many people who do not know me," she commented, "believe I would be 'better off dead.'" This sort of view is based mainly on ignorance, or even prejudice, argued Campbell. Lord Joffe's Bill failed to get the endorsement of a single organization of disabled

⁴¹ Allen, M. L., *Crossing the Rubicon: The Netherlands' Steady March Towards Involuntary Euthanasia*, Brooklyn Journal of International Law 2006 31:2 535-575.

people. Groups representing the terminally ill and disabled, alarmed by what the Bill sought to achieve, formed a coalition, *Not Dead Yet*, to fight the proposal.⁴²

Patient autonomy is not well served by legal euthanasia as was found in the Netherlands:

In the end, the balance that the Dutch government has attempted to strike between patient-autonomy principles and physician beneficence has not succeeded. Their approach to euthanasia regulation does not protect vulnerable individuals from potential abuse, fails to provide physicians with incentives to comply with the statutory reporting requirements, and as a practical matter, fails to prevent involuntary euthanasia.

Although the Dutch government speaks the language of patient rights, relief from suffering, and death with dignity, it has created a system in which physicians, not patients, control the circumstances of death.⁴³

Politicians defending passage of euthanasia laws demonstrate stark contradictions in their arguments that ‘safeguards’ in the proposed legislation will ensure that there are strict criteria for access to euthanasia/assisted suicide: age limitations; only certain illnesses, predicted mortality; medical approval, and so on. For example the *Voluntary Assisted Dying Bill 2017* (Vic.) places numerous restrictions on access to its provisions: persons must be over 18 and resident in Victoria; persons must be deemed able to make decisions and suffering from an incurable illness; patients must be experiencing intolerable suffering, and expected to die within a year; and, in all, some 68 safeguards in the legislation

Why should there be any limits on access to assisted suicide in view of the argument of vaunted autonomy of each person? Pro-euthanasia advocates and politicians have invariably proposed arbitrary restrictions in every euthanasia/assisted suicide Bill ever to be presented whether in Australia or overseas.

To make euthanasia provisions more palatable to people generally, they act so in the face of clear evidence that once the law allows in principle that life may be deliberately taken with State approval, then any moral argument that this permission can be restricted to end of life situations cannot be sustained. Perhaps the absolute right to choose death at another’s hands, as espoused by Dr Philip Nitschke, is at least consistent with rigid ideological adherence to the principle of autonomy however wrongly applied in this context.

XIII. Conclusion

Palliative care is advancing very rapidly, both in relieving suffering experienced by those with a terminal illness, as well as in providing support for their families. Politicians should take steps to ensure adequate training is given to doctors and nurses to adequately treat such patients; they should also fund the establishment of centres of specialist palliative care. They should ensure that the law continues to affirm the principle that life is precious especially in its most challenged, vulnerable moments. The Attachment is an eloquent statement of these life-affirming principles.

⁴² *The Guardian* 9 May 2006.

⁴³ See footnote 34.

Odette Spruyt*

The Age 5 February 2007

RECENT articles and letters after the death of Dr John Elliott have presented dying in Australia as a fearful and terrible experience. People are said to suffer not only physically but also a total loss of dignity such that desperate people have no choice but to take extreme measures.

Human dignity is presented as totally dependent on fragile externals. We lose our dignity in the face of suffering, be it physical, emotional or social. We lose our dignity if we lose control of our decision-making capacity, our bowels, our mobility, our mind. We lose our dignity if our loved ones can't or won't care for us and we refuse to let others do so.

The subversive practice of giving patients lethal doses of morphine is portrayed as commonplace and indeed necessary for pain-free dying within the constraints of what is inferred to be archaic, inhumane and ineffective health care for the dying.

I have worked as a specialist palliative care doctor for 13 years. The exposure to death and dying daily has taught me many lessons. When I read the story of Elliott, some apparent absences are disturbing: the absence of an extended care network, the absence of any mention of palliative care/pain management expertise, the absence of the will to live (portrayed as somehow heroic). This is one man's story. It is certainly not everyman's story.

In Australia over the past 10 years, there has been an impressive increase in the range of pain management drugs. We now have more than 10 strong pain killers (opioids) that can be given in many different ways so that finding the right drug for the individual is now possible. In addition, we have a vast array of supportive pain-relieving drugs that can be combined with the opioids, to safely minimise the dose of opioid and optimise pain relief. Combinations often achieve more than one drug alone but are more complex for the patient, carer and doctor to manage, hence the need for specialist palliative care/pain management assistance.

Added to the medications now available are many other treatments such as radiotherapy, specialised anaesthetic techniques for cancer pain relief (such as epidurals), neurosurgical techniques and anticancer treatments, which may reduce the tumour size and activity and so reduce the tumour-associated pain. We also have a national, free palliative care network, available to all, providing care for the dying in hospitals, hospices and at home.

It is simplistic to argue that palliative care can remove all suffering at the end of life. However, why is it that at a time of such greatly improved analgesia and systems of care, the envy of many countries worldwide, there appears to be such a great fear of dying in unrelieved pain and suffering? Our resources have never been better. Why are people being told that there is nothing to help them?

As a community, we do need a better understanding of palliative care as specialised health care for those approaching death. Palliative medicine is also not well understood by the medical community, which leads to ignorance in the use of analgesics, even by experienced doctors. For example, it is inaccurate to say that such large doses of narcotic analgesia as would suppress breathing and shorten life are necessary to relieve pain in the dying.

A recent review of hospice practice showed that the norm is modest doses of opioids in the final 48 hours of life. This is evidence that with best total care, extreme dosing is not required for a peaceful death and may in fact achieve the opposite due to side effects. In addition, such

rhetoric reinforces the negative stereotypes that abound about the medical use of opioids and prevents many patients from accepting appropriate pain relief out of fear that these drugs will kill them.

However, perhaps it is not the fear of pain and suffering but rather a fear of death itself that drives this issue.

In fact the fear of death may be greater than ever before in our youth-oriented culture. Perhaps we need to slow down. In our rush to the finishing line, we are failing to see:

- The tireless devotion of a young wife for her dying husband.
- The marriage in hospital of a long-together couple two days before his mother dies.
- The exquisite intimacy and tenderness of a mother as she cares for her dying 20-year-old daughter.
- The laughter of families as they reminisce around the bedside of their father.
- The children doing puzzles on the floor of their grandmother's hospice room.
- The daily courage and dignity of the ill in the midst of incontinence, pain, tears and grief.
- The urgency in the steps of the nurses intent on relieving the pain and distress of their patient.
- The friendship and love which grows between staff and patients in the midst of adversity.
- Life renewing in the face of death.

We may crave for a way to circumvent the pain of dying, the grief, the loss and the seeming uselessness of it all. We may prefer a neater exit of our own time and choosing. However, we risk anaesthetising ourselves from life, and losing much of its richness, mystery, beauty and soul.

Instead of running from death, we need to embrace those who are dying within the community of the living and ensure that they know they are a vital part of life until their last breath.

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