

SUBMISSION TO THE SENATE  
LEGAL AND CONSTITUTIONAL  
AFFAIRS COMMITTEE  
RE THE  
RIGHTS OF THE TERMINALLY ILL  
(EUTHANASIA LAWS REPEAL)  
BILL 2008

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8.9.08

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That living is a process is a generally accepted concept in our society. Dying is also part of the life process which cannot be avoided, but for which traditional medical and nursing ethics have shown a deep respect.(1) It is a reasonable expectation that people should not die in overwhelming circumstances of suffering or pain. Indeed with modern, accepted medical practice, such an extreme should be thought of as outdated and unnecessary, but behind the times in regards to good palliative care. Most would agree that the ill and the dying deserve every consideration and compassion to allow them a relatively "easy" natural death. Such practice is already common in Australia. Yet presently the Australian parliament will debate the overturning of legislation to once again allow physician-assisted suicide in the Northern Territory. In doing so, it is important to review the psychological arguments in considering euthanasia.

In general terms, the Australian Psychological Association has identified a number of key areas for consideration concerning euthanasia. Issues arising include:

1. The patient's competence to request euthanasia, assessed on more than one occasion
2. The competence of the subsequent decision-making by all concerned
3. The wide range of clinical, social, physical and psychological factors involved in the patient's condition that could bear upon a request to die
4. The physical and mental state of the carer(s)
5. The adequacy of total care provided to the patient with special reference to palliative care, but including physical, medical, psychiatric and psychological care
6. Quality assurance around the response to a request eg that it could be reversed during a cooling off period and that standards of care are maintained during that time
7. Best practice in terms of psycho/social support requiring that the patient fully understands his/her alternatives and the ramifications of his/her decisions
8. The psychological needs of significant others and carers
9. The need to avoid carers' personal views affecting the objectivity of the decision making for the patient and affecting assessment by medical professionals(2)

The Australian Psychological Association further suggests:

"Any patient with a serious medical illness or potentially terminal condition is entitled to the same thorough psychological and/or psychiatric assessment and treatment as those without physical morbidity. Voluntary euthanasia may be the preferred option of some terminally ill patients, but it requires careful examination of all possible medical, palliative, psychiatric and psychological factors, which may contribute to the request. Thus a patient's request for euthanasia ...is not sufficient justification for acquiescence."(3)

In relation to the Northern Territory Rights of the Terminally Ill Act 1995, these considerations are of particular significance as the Act specifically targets the individual as the sole decision maker regarding his/her future.

Part 2, Section 4 of the Act states:

" A patient who, in the course of a terminal illness, is experiencing pain, suffering and /or distress to an extent unacceptable to the patient, may request the patient's medical practitioner to assist the patient to terminate the patient's life."

Part 2, Section 7, subsection 1 (ii) states:

"...in reasonable medical judgment (that) there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure..."(4)

The Act very clearly spells out that request for assisted suicide is to be based upon patient perceptions of circumstances and experiences. These are very subjective and personal interpretations and responses, which may not be appropriately based in reality.

Helme asserts that a wish to die is often the result of mental illness.(5) It is certainly the current practice in our society to deem any other person attempting suicide as in need of psychiatric care and much attention and resources are put into suicide intervention programs and strategies. Psychiatric disorders such as depression, anxiety disorder, delirium or adjustment disorder may also affect decision making.(6)

Patient feelings of burden or guilt in response to professional, family or community discomfort, fear of dependency or loss of control or loss of a sense of self worth may also influence the patient.(7)

The APA has also suggested that unrecognized and untreated psychiatric morbidity in carers, family members, or other health care providers may also influence a seriously ill patient's thinking. Carer and professional fatigue, anxiety, depression and despair may also impact on the patient.(8) The Society further suggests that boundaries between terminally ill patients and carers or family members are not always clear. Emotions can be projected and it is sometimes difficult to discern who is feeling the most emotional, psychological or spiritual pain.(9)

Other factors for consideration may be that a request for euthanasia may follow a failure of one or more functions of the health care system to provide adequate care. Misdiagnosis, inadequate medical, psychiatric or palliative care may influence patient perceptions.(10) Loneliness and fear of death, fear of a slow death, fear of pain, fear of not being able to breathe, fear of incontinence or loss of dignity may also cause a patient to request a premature death.(11)

The legislation under review only provides for a psychiatric assessment to determine whether or not a patient is suffering from depression in legalizing his/her assisted suicide. As can be seen quite clearly from the aforementioned considerations, there can be many factors influencing patient thinking about wanting to die. Each will be particular to the individual, but all can be assisted in ways other than killing the patient.

Consideration should also be given to impact upon doctors, nursing staff and other health care professionals in expecting them to change what has traditionally been seen as a healing and/or caring role into that of killer. Although the legislation provides an "opt out clause" for health care professionals, they too are human with all the potential to experience suffering, coercion, moral dilemma, stress etc which such a change in role could involve.

In specific response to the Northern Territory Right of the Terminally Ill ACT 1995, The Australian Psychological Society has said:

"In excluding psychological disorders which may influence a patient's decision, the emphasis in the Act is upon clinical depression. There are several alternative clinical possibilities such as

'related toxic or other organic brain syndrome', anxiety disorders, delirium and adjustment disorders. The influence of other individual and relationship issues on decision making should also be considered."(12)

Furthermore, "... neither the Act ... nor regulations make provision for the need to address the psychological needs of close relatives of the patient through counselling..."

"Given the spread of the population of the NT over rural and remote areas, access to a psychiatrist may be difficult for some patients."(13)

The Rights of the Terminally Ill Act 1995 should be seen exactly for what it is – physician assisted suicide. It is not a variation on care and should never be viewed as such. It requires the active collusion and participation of doctors and psychiatrists to kill a patient. It is an extreme solution to a situation fraught with problems. It is not enough that our society deals with any of the aforementioned considerations by sweeping them under the carpet in allowing patients to request death and give it to them. This is not a simple or private issue between a patient and his/her doctor. It is a choice that reflects and impacts upon all ethical, moral, social and spiritual norms of our society.

### References

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