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The Euthanasia Debate

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CSBQ Discussion paper

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(see also CSBQ statement and Submission to SA Select Committee)

THE EUTHANASIA DEBATE

by Dr Rob Pollnitz

The assisted suicide of Nancy Crick in her Gold Coast home on 22 May has reawakened the debate over euthanasia in Australia. This was her intention. She contacted EXIT Australia, the pro-euthanasia group headed by Dr Philip Nitschke, and 3 months before her death they set up the Nancy Crick project, with a dedicated internet site (www.nancycrick.com) and frequent publicity releases.

Nancy Crick was an appealing character, a very Australian former factory worker and barmaid in her 70th year. She had retired from Melbourne to Burleigh Heads in 1989, the same year that her husband Jimmy died of a heart attack. Her photos show a face ravaged by over 50 years of smoking, and indeed those present report that after taking her lethal dose of barbiturates she dragged on a cigarette until she lost consciousness.

In 1999 Mrs Crick had surgery for bowel cancer. Her web diary describes her as "terminally ill .. dying of bowel cancer ... a 27 kg shell .. in almost constant pain .. I've lost the will and desire to live." Committing suicide is not illegal, but there is a law with a maximum penalty of life imprisonment for assisting a suicide. EXIT's Nancy Crick project was to test this law by having 20 people present at the suicide, with the aim of changing Australian law to permit euthanasia "as a right of all terminally people."

For those who are new to the debate, euthanasia can be defined as intentionally taking the life of a patient, either by a deliberate act (as with giving a lethal dose) or by the deliberate omission of ordinary care (as with not offering milk feeds to a baby who has a disability). This should not be confused with turning off machines, or stopping unwanted treatments. In euthanasia, the key is that death is the intended outcome. Essentially the euthanasia debate is about giving lethal injections. Those who favour euthanasia always describe it as "voluntary" and present it as a simple issue of autonomy, of personal freedom of choice – it's my life, and I should have the right to die when I choose. But I would argue that euthanasia and suicide are different. By always involving a second person, euthanasia is about how we as a community respond to someone who is suicidal.

Returning to Nancy Crick, in the week following her death the news leaked from the Brisbane Coroner's office that Mrs Crick's autopsy showed no visible cancer. She was not terminally ill. She weighed 38 kg and was gaining. She was reported to have a

“twisted bowel” (I presume a partial intestinal obstruction from adhesions, usually correctable by surgery). Both she and Dr Nitschke had known that she no longer had cancer for 2 months before she committed suicide. Mrs Crick had described being abused by EXIT supporters when at one stage she opted to try palliative care. Queensland Dr David Van Gend believes that Mrs Crick was unduly pressured into her suicide. “An atmosphere of expectation was put on this lady from which she could not retreat without extreme loss of face. The social and personal web around Nancy Crick is akin to the psychological and emotional entanglement of a cult.” Dr Nitschke dismissed any criticism: “Mrs Crick’s chronic pain gave her a right to die. Whether she had cancer was irrelevant.”

Those who favour euthanasia have made three other efforts in Australia so far this year. Green MP Ian Cohen introduced a bill to allow euthanasia in the NSW Upper House, and on 21 March that bill was defeated by 26 votes to 9. In May the Australian Medical Association had its National Conference in Canberra, and delegates heard a debate between Dr Nitschke and Prof Margaret Somerville. A motion that the AMA change from its present opposition to euthanasia to a neutral stance was defeated by 79 votes to 34. And in SA, Democrat Sandra Kanck reintroduced her bill to permit euthanasia in the Upper House on 8 May. A select committee of that House rejected the same bill in October 1999.

The Kanck bill demonstrates many of the weaknesses of all previous euthanasia bills. Any person of 18 years or more who is “hopelessly ill ... so that life has become intolerable to that person” can request a lethal dose. Any illness does not have to be incurable or terminal – the language is entirely subjective. A newly diagnosed diabetic aged 18 who found the idea of daily insulin injections “intolerable” would qualify. A doctor must agree, even two doctors “if reasonably practicable.” The doctor need have no experience – a new graduate will suffice. The doctor should be satisfied that the patient “appeared to be of sound mind .. appeared to understand .. did not appear to be acting under duress.” None of these points need to be verified. The doctor should have “no reason to suppose” that the patient is depressed. This when treatable depression is a common reason for people with illness to seek euthanasia, and when doctors often miss that diagnosis.

Oh, and the doctor should report the death to the Coroner. Since the doctor will be the chief player, the sole survivor and the only author of the report, the chances of the Coroner learning anything she or he was not meant to find will be close to zero.

All euthanasia bills place great faith in the judgment of doctors. Sadly we doctors share the human ability to make mistakes. Even a good doctor can make a wrong diagnosis, we can label an illness terminal when it is not, and we are hopeless at predicting when patients are going to die. People do make unexpected recoveries – provided they have not been given lethal doses. And not all doctors are good doctors. There are doctors in practice who are emotionally unstable, and there are others who abuse alcohol or drugs. None of us should be trusted with the right to kill.

Hopelessness does have an association with requests for euthanasia. Psychiatrist Harvey Khochinov finds that the one difference between people with life-threatening

illness who wanted euthanasia as compared with those who did not was a sense of hopelessness. Ethicist Margaret Somerville argues that “Euthanasia confirms the power of death over hope. It fails to recognise the great mystery that allowing death to occur, when its time has come, is an act of life . If someone can look forward to a visit from someone they love or to see their grandchild, or even to hear the birds get up in the morning or see the sunrise, that’s enough hope to make that period of life still worth living.” She notes that in Oregon, the one state in the USA that allows physician-assisted suicide, 46% of people who had obtained their lethal drugs changed their minds when they received good palliative care.

Writing about losing hope reminded me of Elijah. In 1 Kings 19 a weary and fearful Elijah calls on God to take his life. God does not answer directly, but provides Elijah with restful sleep and food and drink. And when Elijah is strong again, he returns to the work of the Lord.

Last year Norma Hall of Sydney had assistance to die from Dr Nitschke. Now a Melbourne woman, Sandy Williamson, has told 60 Minutes that she wants his help. Between 1990 and 1997 in the USA, Dr Jack Kevorkian helped 93 people to die, and two-thirds of them were women. Observers believe that sick and disabled women are more likely to feel themselves a burden, because for the first time in their lives they are being cared for rather than providing the care. It is their diminished sense of self-worth that leads them to ask for death. Perhaps they are really saying, “Do you care enough to want me alive, to be willing to help me carry the load?”

Those who favour euthanasia point to Holland as a shining example. In 1984 the Supreme Court of the Netherlands decided that voluntary euthanasia would not be punished, provided that certain conditions were observed. No supervision of the guidelines was provided. Slowly lethal doses for the sick and aged became a part of medical practice for some doctors. When 8 years later Dr John Keown of Britain examined the Dutch system, he found that over 50% of the acts done or omissions made with the intention of causing death were taken <u>without</u> the consent of the patient. The doctors had come to believe that they were the best judges of when people had reached their use-by date. Over 50% were not reporting cases of assisted death to the Coroner. More recently a Dutch court found a Dr Chabot was justified in giving a lethal dose to a physically well woman of 50 who was depressed and feeling suicidal after the deaths of two of her children and the break-up of her marriage. So in Holland now, grief and emotional distress will qualify you for a lethal dose.

Some doctors in Holland now will provide the “benefits” of euthanasia to older children, those between 12 and 17 years. When in 1997 Dr Nitschke spoke of developing a suicide pill made from readily available ingredients, with the details to be published on the internet, critics noted that Australia already has one of the highest rates of youth suicide in the world. In 1999 Dr Nitschke said of the trend in Holland: “At a certain age you become old enough to understand about death, and if your life is no longer worth living according to your estimation, you have a right to give it away.” (The so-called “peaceful pill” recipe remains elusive).

Australia has experimented with legal euthanasia for a brief period. The Northern Territory law allowing lethal injections came into effect in June 1996 and was overturned in March 1997. This law was pushed through the one-house NT Assembly in one 16-hour sitting, essentially by the efforts of one charismatic leader, Marshall Perron. In 1999 Prof David Kissane (a palliative care specialist) reviewed the NT experience of 7 deaths during that legal window. He noted that "Pain was not a prominent clinical issue in our study. Fatigue, frailty, depression, and other symptoms contributed more to the suffering of patients. There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care."

Government supported inquiries in Britain, the USA and Canada have begun with members who were in favour of euthanasia, and yet despite these personal views they came to realise that they could not craft a law that would not endanger the lives of their most vulnerable citizens – the aged, the sick and the disabled who do not wish to die. Here is an extract from the New York State Task Force: "No matter how carefully any guidelines are framed, euthanasia will be practised through the prism of social inequality and bias that characterises the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care."

We are fortunate to be Australians and to have world-best palliative care available in our major centres in 2002. Some of us will die early, and some swiftly, and some will have a final illness in which we will need skilled palliative care to help us live well until death comes. Psalm 139 reads in part: "When I was woven together in the womb your eyes saw my unformed body . All the days ordained for me were written in your book before one of them came to be." It comforts me to know that God has his own detailed plan for each one of us. And as Christians we have the ultimate medicine of knowing that this life is not all, but rather that since Christ died for us we cannot be separated from God even when our own death comes. These winter mornings I think of 1 Corinthians 15, and dare to hope that my glorious new resurrection body will move better than this one.

CSBQ statement on Euthanasia

Submission to SA Select Committee on Euthanasia