2014/19: Should voluntary euthanasia be made legal in Australia?

What they said...
...with the development of modern methods of palliative care, legalisation of euthanasia is unnecessary
1990 United Nations World Health Organisation expert committee

... even the best of palliative care cannot help all patients between 5-10% find their suffering so unbearable that they persistently request an assisted death
South Australian Voluntary Euthanasia Society

The issue at a glance
Toward the end of 2014 a number of events occurred which had some sections of the Australian media addressing the question of whether voluntary euthanasia should be legally available in this country.
In October, 2014, euthanasia advocate, Dr Rodney Syme, was interviewed by police after a confession he made in April 2014 that nine years before he had supplied a dying cancer patient with a drug the man then used to commit suicide. The investigation is still ongoing.
Between November 10 and November 12, 2014, the Northern Territory Health Professional Review heard Dr Philip Nitschkes appeal against his suspension by the Medical Board of Australia (MBA).
The MBA claimed that Nitschkes alleged support of what is sometimes referred to as rational suicide presented a serious risk to public safety. Dr Nitschke is accused of having provided assistance to a man who, though suffering no terminal illness, ended his own life. The appeal hearing has been temporarily concluded; however, no judgement has yet been made.
In October 2014, after a four month Senate Inquiry, a draft of Greens Senator, Richard di Natale's Medical Services (Dying with Dignity) Bill 2014 was tabled in Federal Parliament and is set to be debated early in 2015 when Parliament reconvenes.
The question of under what circumstances, if any, euthanasia should be available in Australia will obviously continue to be discussed.

Background
(The following information is an abbreviated version of the Wikipedia entry titled euthanasia. The full entry can be accessed at http://en.wikipedia.org/wiki/Euthanasia
The information regarding euthanasia in Australia comes from the Wikipedia entry which can be accessed at http://en.wikipedia.org/wiki/Euthanasia_in_Australia)

Euthanasia refers to the practice of intentionally ending a life in order to relieve pain and suffering.
There are different euthanasia laws in each country. The British House of Lords Select Committee on Medical Ethics defines euthanasia as a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering. In the Netherlands, euthanasia is understood as termination of life by a doctor at the request of a patient.
Euthanasia is categorised in different ways, which include voluntary, non-voluntary, or involuntary. Voluntary euthanasia is legal in some countries, American. states, and Canadian Provinces. Non-voluntary euthanasia is illegal in all countries. Involuntary euthanasia is usually considered murder. As of 2006, euthanasia is the most active area of research in contemporary bioethics.
In some countries there is a divisive public controversy over the moral, ethical, and legal issues of euthanasia. Those who are against euthanasia may argue for the sanctity of life, while proponents of euthanasia rights emphasize alleviating suffering, bodily integrity, self-determination, and personal autonomy. Jurisdictions where euthanasia or assisted suicide is legal include the Netherlands, Belgium, Luxembourg, Switzerland, Estonia, Albania, the US states of Washington, Oregon and Montana, and, starting in 2015, the Canadian Province of Quebec.

Classification of euthanasia

Euthanasia may be classified according to whether a person gives informed consent into three types: voluntary, non-voluntary and involuntary.

Voluntary euthanasia

Euthanasia conducted with the consent of the patient is termed voluntary euthanasia. Active voluntary euthanasia is legal in Belgium, Luxembourg and the Netherlands. Passive voluntary euthanasia is legal throughout the United States per Cruzan v. Director, Missouri Department of Health. When the patient brings about his or her own death with the assistance of a physician, the term assisted suicide is often used instead. Assisted suicide is legal in Switzerland and the United States states of Oregon, Washington and Montana.

Non-voluntary euthanasia

Euthanasia conducted where the consent of the patient is unavailable is termed non-voluntary euthanasia. Examples include child euthanasia, which is illegal except in Belgium and The Netherlands where it is decriminalised under certain specific circumstances under the Groningen Protocol.

Involuntary euthanasia

Euthanasia conducted against the will of the patient is termed involuntary euthanasia.

Passive and active euthanasia

Voluntary, non-voluntary and involuntary euthanasia can all be further divided into passive or active variants. Passive euthanasia entails the withholding of common treatments, such as antibiotics, necessary for the continuance of life. Active euthanasia entails the use of lethal substances or forces, such as administering a lethal injection, to kill and is the most controversial means. A number of authors consider these terms to be misleading and unhelpful.

In Australia it is legal to withhold burdensome treatments; this can include intubated feeding. It is also legal to administer pain-relieving drugs with the unintended consequence of hastening death. In neither case is this termed euthanasia.

Euthanasia in Australia

Although it is a crime to assist in euthanasia, prosecutions have been rare. In 2002, relatives and friends who provided moral support to an elderly woman who committed suicide were extensively investigated by police, but no charges were laid. The Commonwealth government subsequently tried to hinder euthanasia with the passage of the Criminal Code Amendment (Suicide Related Materials Offences) Bill of 2004. In Tasmania in 2005 a nurse was convicted of assisting in the death of her elderly father, who had terminal cancer, and trying to kill her mother, who was in the early stages of dementia. She was sentenced to two and a half years in jail but the judge later suspended the conviction because he believed the community did not want the woman jailed. This sparked debate about decriminalising euthanasia. Decriminalisation of Euthanasia in Australia is supported by the Australian Greens, the Secular Party of Australia, the Australian Sex Party, the Australian Democrats, and the Liberal Democratic Party.

In 2008 Shirley Justins and Caren Jennings, were found guilty of manslaughter and accessory to manslaughter respectively for providing Nembutal to former pilot Graeme Wylie in 2006. Justins stated that Wylie wanted to die with dignity. The prosecution argued that Graeme Wylie did not have the mental capacity to make the crucial decision to end his life, classing it as involuntary euthanasia.

In August 2009, the Supreme Court of Western Australia ruled that it was up to Christian Rossiter, a 49 year old quadraplegic, to decide if he was to continue to receive medical care (tube feeding) and that his carers had to abide by his wishes. Chief Justice Wayne Martin also stipulated that his carers, Brightwater Care, would not be held criminally responsible for following his instructions. Rossiter died on 21

September 2009 following a chest infection.

Exit International made TV ads arguing for voluntary euthanasia, which were banned just before they were scheduled to broadcast in September 2010.

Legalisation in the Northern Territory
Euthanasia was legalised in Australia's Northern Territory, by the Rights of the Terminally Ill Act 1995. It passed by a vote of 15 to 10 and a year later, a repeal bill was brought before the Northern Territory Parliament in August 1996, but was defeated by 14 votes to 11.[7] Soon after, the law was voided by an amendment by the Commonwealth to the Northern Territory (Self-Government) Act 1978. The powers of the Northern Territory legislature, unlike those of the State legislatures, are not guaranteed by the Australian constitution. However, before the Commonwealth government made this amendment, three people had already died through physician assisted suicide under the legislation, aided by Dr Philip Nitschke. The first person was a carpenter, Bob Dent, who died on 22 September 1996.

Tasmania
The closest euthanasia has come to being legalised by a state was in Tasmania in 2013, when a Greens' voluntary euthanasia bill was narrowly defeated in the Tasmanian House of Assembly by a vote of 13-12. Although both major parties allowed a conscience vote, all ten Liberals voted against the legislation, with Labor splitting seven in favour and three against, and all five Greens voting in favour.

Organisations
The euthanasia advocacy group YourLastRight.com is the peak organisation nationally representing the Dying with Dignity associations of Queensland, New South Wales, Victoria and Tasmania, as well as the South Australian Voluntary Euthanasia Society (SAVES), the Western Australian Voluntary Euthanasia Society (WAVES) and the Northern Territory Voluntary Euthanasia Society (NTVES).
Exit International is an Australian euthanasia advocacy group founded by Philip Nitschke. Other Australian groups include Christians Supporting Choice for Voluntary Euthanasia and Doctors for Voluntary Euthanasia Choice.
Australian institutions and organisations that oppose the legalisation of euthanasia are groups such as HOPE and the Australian Catholic Church.
The Australian Medical Association does not support euthanasia.

Internet information
On December 20, 2014, the anti-euthanasia lobby group HOPE published a comment by Paul Russell titled Fairfax Press beats up on euthanasia. Russell argues that the Fairfax media have exaggerated popular demands for euthanasia in its newspapers recent treatment of the issue.
The full text of this comment can be found at http://www.noeuthanasia.org.au/blog/2180-fairfax-press-beats-up-on-euthanasia.html

On November 17, 2014, The Canberra Times published a comment by Jack de Groot titled The euthanasia lobby has hijacked the phrase dying with dignity. The piece argues that a dignified death is possible without resort to assisted suicide.
The full text can be accessed at http://www.canberratimes.com.au/comment/the-euthanasia-lobby-has-hijacked-the-phrase-dying-with-dignity-20141116-11mpcg.html

Dying with Dignity NSW has published a collection of letters to the editor sent to the Age and The Sydney Morning Herald in the first fortnight of November, 2014. These letters all argue on favour of the legalisation of voluntary euthanasia.
They can be accessed at http://dwdnsw.org.au/letters-age-smh/

On October 25, 2014, ABC News posted a report on Martin Burgess, a euthanasia advocate and cancer suffer, who died after having posted a request on YouTube that someone supply him with a substance to end his life.
The full text of this report can be found at http://www.abc.net.au/news/2014-10-24/euthanasia-advocate-martin-burgess-dies-in-darwin/5840696

On September 25, 2014, the anti-euthanasia lobby group HOPE republished a comment by Dr Kevin Fitzpatrick criticising a doctor, previously convicted in New Zealand for assisting his mothers death, for helping a South African quadriplegic to commit suicide.
The full text can be found at http://noeuthanasia.org.au/blog/2113-euthanasia-and-they-say-that-people-with-disabilities-have-nothing-to-fear.html

On August 10, 2014, The Sydney Morning Herald published a comment by euthanasia advocate Dr David Swanton titled Time for euthanasia debate to reach regulations.
Swanton defends the conduct of Dr Philip Nitschke and argues that those concerned about the practice legalised so that proper safeguards can be applied.
The full text of this comment can be found at http://www.smh.com.au/it-pro/time-for-euthanasia-debate-to-reach-regulations-20140810-101xos.html

On July 8, 2014, The Conversation published an opinion piece by Paul Biegler, Adjunct Research Fellow in Bioethics at Monash University titled Memo to Philip Nitschke: lets keep euthanasia for the dying.
Biegler argues that euthanasia should not be extended to include the non-terminally ill.
The full text of this comment can be found at http://theconversation.com/memo-to-philip-nitschke-lets-keep-euthanasia-for-the-dying-28846

On October 16, 2013, The Mercury published an opinion piece titled Voluntary euthanasia: The case against. It is written by Michael Cook, the editor of the online bioethics news service BioEdge, and uses developments in Belgium where voluntary euthanasia is legal to argue against its introduction in Tasmania.
The full text of this article can be found at http://www.themercury.com.au/news/opinion/voluntary-euthanasia-the-case-against/story-fnj4f64i-1226740819361?fb_action_ids=640012582705097&fb_action_types=og.recommends

In 2013 the Medical Journal of Australia published an article by John O Willoughby, Robert G Marr and Colin P Wendell-Smith, on behalf of Doctors for Voluntary Euthanasia Choice.
The article is titled Doctors in support of law reform for voluntary euthanasia
The piece presents the case for voluntary euthanasia. It can be accessed at https://www.mja.com.au/journal/2013/198/4/doctors-support-law-reform-voluntary-euthanasia

On December 1, 2012, the British newspaper The Guardian published a report titled Half of those on Liverpool Care Pathway never told. The report indicated that nearly half of the terminally ill hospital patients in Britain marked for limited care that might hasten their deaths were not told that this was the case.
The full text of this report can be found at http://www.telegraph.co.uk/health/healthnews/9716418/Half-of-those-on-Liverpool-Care-Pathway-never-told.html

In April 2011, the Canadian-based and internationally distributed journal Current Oncology published an article by José Pereira titled Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls
Pereira uses a survey of existing literature to demonstrate that safeguards and controls around legalised euthanasia have not been fully applied.

The full text of this article can be found at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3070710/

In 2011, Life Org New Zealand published a review of current palliative care practices, arguing that pain management was almost always effective.
The full text of this article can be found at http://www.life.org.nz/euthanasia/euthanasiafaq1

Arguments in favour of the legalisatation of voluntary euthanasia
1. Euthanasia should be available, at the request of those enduring terminal illness
Those who support euthanasia typically do so when it has been freely chosen by a person suffering, or anticipating, significant distress as the result of a terminal illness. More than 75 percent of Australians typically answer yes to the following Morgan Gallop poll question, If a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering, asks for a lethal dose, should a doctor be allowed to give a lethal dose or not ?
Those who believe that euthanasia should be available under these circumstances generally argue that the individual has the right to assistance to end his or her life prematurely when enduring a fatal disease that is causing him or her physical or psychological distress. Supporters of this position see it as the individual exerting control over the circumstances of his or her life and the manner of its ending. They argue that the choice primarily affects the suffering individual and that ending a persons life at his or her request under these circumstances advantages the individual and does not harm others.
Supporters claim that euthanasia or assisted suicide should not be seen as murder on the part of the physician, because the patient is already facing imminent death. It is also argued that the act is not murder because it follows the wishes of the patient.
The question is often argued in terms of human rights, with supporters of voluntary euthanasia claiming that any sane, informed human being should be able to choose physician assisted suicide in the face of incurable, distress-inducing, terminal illness. Euthanasia advocate Philip Nitschke argues that a right to life carries with it a right to surrender that life.
In 2011 Dr David Benatar, of the Philosophy Department of the University of Cape Town, stated, To be forced to continue living a life that one deems intolerable when there are doctors who are willing either to end ones life or to assist one in ending ones own life, is an unspeakable violation of an individuals freedom to liveand to dieas he or she sees fit.

2. Safeguards can ensure that only appropriate candidates are euthanised
It has been claimed that any legislation allowing for euthanasia or physician assisted suicide would be surrounded with sufficient safeguards to ensure that the law would not be abused.
A BBC ethics guide available in 2014 discussing the regulation of euthanasia made the following stipulations. For safeguards to be meaningful and effective, they have to involve investigations of the patient's psyche, his family dynamics and the financial implications of his death, along with more obvious things such as the patient's medical condition and the likely course of the disease.
In order to ensure that requests are properly considered, by the patient, the family and the authorities, regulations need to build in a time-period for reconsideration.
Proper regulation must also make sure that a patient was receiving good palliative care before a request for euthanasia is considered.
The Northern Territorys Rights of the Terminally Ill Act 1995 attempted to put safeguards in place that would ensure that euthanasia was not abused. These safeguards included
that the patient has attained the age of 18 years; that a first medical practitioner is satisfied, on reasonable grounds, that the patient is suffering from an illness that will result in the death of the patient and that there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure; and that any medical treatment reasonably available to the patient is confined to the relief of pain, suffering and/or distress. A second medical practitioner must confirm these judgements. The patient must not be suffering from a treatable clinical depression in respect of the illness and the illness must be causing the patient severe pain or suffering.

The patient must be fully informed of the nature of his or her illness, the prognosis and available treatment options. The patient must be of sound mind and the decision to end his or her life must have been made freely, voluntarily and after due consideration.
The US state of Oregon is sometimes put forward as a jurisdiction with a rigorous set of safeguards surrounding the use of euthanasia. Oregon legalised physician-assisted suicide in 1998. During the first three years, only around two people a month used this to end their lives. This was partly because of the severe conditions that had to be satisfied before a request for euthanasia could be granted. These conditions state: the patient must be resident in Oregon; the patient must be aged over 18; the patient must make two oral and one written request for euthanasia; there must be at least 15 days between the first and the last request; the patient must be terminally ill with a life expectancy of less than 6 months; this prognosis must be confirmed by a second consultant physician; both doctors must confirm that the patient is capable of making this decision; both doctors must confirm that the patient does not have medical condition that impairs their judgement; the patient must self-administer the lethal medication.
About 30% of patients who started the process died before it was completed. 19 patients in the period who were given access to lethal medication decided not to use it. One survey showed that 45% of patients who were given good palliative care changed their mind about euthanasia.
Not all supporters of euthanasia favour a regime as strict as Oregons, but that jurisdictions safeguards are used as an example of the manner in which abuses can be prevented.

3. Any expanded categories for euthanasia would be cautiously implemented and legally determined
Supporters of euthanasia being made legally available in Australia argue that any expansion of the practice would only occur if it were legally sanctioned.
Australias legislatures have been very cautious in their implementation of euthanasia. Despite many private members bills seeking to make euthanasia legal having been tabled in different states, such legislation has only been passed in the Northern Territory and then was overturned by federal legislation.
Supporters of law reform note that this caution is likely to persist and that if euthanasia were made legal any extension of its use would be implemented with equal care.
This point was made in an article published in The Conversation on February 17, 2014. The authors, Ben White, Professor in the Faculty of Law at the Queensland University of Technology and a Director of the Australian Centre for Health Law Research and Lindy Willmott, Professor of Law at Queensland University of Technology and a Director of the Health Law Research Centre at the University, have stated, With the exception of a single act in the Northern Territory, parliaments have been persistent in their refusal to enact legislation that would legalise voluntary euthanasia and/or assisted suicide. Dozens of attempts have been made but only one (in the Northern Territory, and for a limited time) has succeeded.
The Professors concluded, This suggests that should assisted dying become lawful in Australia, a cautious and careful approach would be taken to arguments about widening criteria for who can access the scheme. Further, any such decision-making would invariably be informed by the extensive empirical data that is routinely collected alongside such regimes (assuming such systems were also set up in Australia).

4. Palliative care is not effective for all enduring terminal illness
Supporters of euthanasia claim that palliative care is not always effective and that euthanasia has to be available for those whose distress cannot be relieved.
The South Australian Voluntary Euthanasia Society has stated, It is widely acknowledged, including by Palliative Care Australia and the Australian Medical Association, that even the best of palliative care cannot help all patients between 5-10% find their suffering so unbearable that they persistently request an assisted death.
In 2013 the Medical Journal of Australia published an opinion piece by three doctors representing the Doctors for Voluntary Euthanasia Choice. The doctors state, Dying may be associated with intolerable suffering and there may be a crescendo of suffering as death approaches. Some suffering will only be relieved by death. Some patients rationally and persistently request assistance to die. Palliative care does not relieve all the pain and suffering of dying patients.

Many of those who support euthanasia have had the experience of watching family members or friends die difficult deaths suffering symptoms that could not be adequately alleviated.
In a letter to The Age published on November 13, 2014, Nica Cordover wrote, My husband, Robert, advocated physician-assisted dying. He suffered bulbar-onset motor neuron disease and likened its symptoms to the tortures experienced at Guantanamo Bay: stress positions, sleep deprivation, waterboarding (choking), personal humiliations and, worst of all, the existential suffering of an indeterminate sentence. He faced a death of asphyxiation through choking or lung paralysis. Palliative care is excellent but cannot relieve all suffering of the terminally ill. The choice of the time to die belongs to the sufferer alone.
In another letter published in The Age, similar comments were made, however, the letter writer, whose name was withheld, declared that watching members of his family die without seeking euthanasia had made him the more convinced that he wants access to euthanasia for himself. The letter writer states, My brother has been bedridden since March dying of brain cancer. My mother has dementia and is fearful every moment as everyone is a stranger. My brother is grateful for any time he has; and my mother had always indicated she did not agree with euthanasia. That is their choice and I respect it. However, watching them both dying has made me determined that if I end up in an agonising, drawn-out death, I want my choice for when and how I die respected, too. It frightens me that I will have no choice and may experience 10 years of dying hell. Everyone tells you how palliative care is so good these days. Nobody mentions the distasteful real difficulties, like bleeding bowels, repeated explosive diarrhoea and having to be dosed up on Valium so you dont scream or abuse people. Opposers of euthanasia make dying sound so fun and cosy. I am discovering just how cosy it really isnt.

5. Legalising voluntary euthanasia would help ensure the practice was properly regulated
It has been claimed that if euthanasia were legalised then abuse which may occur while the practice is not legal could be guarded against.
Currently, in Britain, for example, approximately 130,000 people a year are placed on what is referred to as the Liverpool Care Pathway. This is a regime applied to the terminally ill which has what are deemed futile treatments ended in a bid to ease the patients dying. This can include the cessation of life-extending medications, food and water. It can also mean the administration of powerful pain-relieving medication which can have the further consequence of hastening death.
In 2012 the Marie Curie Palliative Care Institute Liverpool and the Royal College of Physicians examined a representative sample of 7,058 deaths which occurred between April and June last year, at 178 National Health Service (NHS) hospitals.
The national audit found that in 44 per cent of cases when conscious patients were placed on the pathway, there was no record that the decision had been discussed with them.
It also found that for 22 per cent of patients on the pathway, there was no evidence that comfort and safety had been maintained while medication was administered. Further, one in three families of the dying never received a leaflet they should have been given to explain the process.
Some critics of the above processes have used them to condemn euthanasia. However, defenders of euthanasia argue that what is being practised here is not regarded as euthanasia by the NHS. Rather, it is referred to as the withdrawal of burdensome treatment.
Euthanasia advocates argue that if Britain were to pass detailed, properly safeguarded voluntary euthanasia legislation then abuses such as those detailed above would not occur.
A similar point has been made in Australia by Dr David Swanton, director of Ethical Rights and the ACT chapter co-ordinator for Exit International. Dr Swanton has stated, If politicians dont like the direction [of] the voluntary euthanasia agenda &they should establish a voluntary euthanasia regulatory framework. Legislation will provide sureties for society and reduce the risk of inappropriate access to information.

Arguments against the legalisation of voluntary euthanasia

1. Patient consent may not be freely given
It has been claimed that consent to euthanasia may not be freely given by a patient.

Firstly, there is the question of the power of the physician to influence a patients judgement. In an article published in Quadrant magazine on January 1, 2011, Brian Pollard wrote, Euthanasia draft bills require doctors to inform patients about the medical details of their illness and future alternatives. Since such discussions will usually occur in private, one could never know whether such information was accurate, adequate, non-coercive and impartial. If the doctors personal view was that euthanasia was appropriate for a patient, we may be sure some would not be deterred from advocating it.
Secondly, concern has also been expressed that some ailing people may feel a burden to their family and loved ones and therefore seek to end their lives out of a sense of guilt or obligation. In a discussion paper prepared for the Australian Psychological Society updated in April 2008 it was stated, Public recognition that euthanasia is available might lead to assaults on individual autonomy. People may be subjected to pressure to ask for their own death by being made to feel guilty for the burden they impose on family and carers. Euthanasia may be offered as an option even when the patient had not previously raised it.
Thirdly, it has been noted that depression is a significant complicating factor when considering whether the choice to end ones life has been freely made. Patients suffering from untreated depression as a co morbidity of a terminal illness are less likely to request euthanasia once their depression has been successfully treated.
The 2008 discussion paper prepared for the Australian Psychological Society stated, A persons expression of a desire to end his or her life may be influenced by a state of depression, uncontrolled pain or dysphoria, conditions which may be relieved by proper treatment. If given such treatment, it is argued that the person may no longer desire to die.

2. Doctors may ignore legal restrictions limiting the application of euthanasia
It has been claimed that legalising voluntary euthanasia creates an environment in which doctors become more likely to practise euthanasia outside the legal restrictions.
In all jurisdictions where physician assisted suicide is legal, the request for euthanasia has to be voluntary, well-considered, informed, and persistent over time. The requesting person must provide explicit written consent and must be competent at the time the request is made. A report by Dr José Pereira, Division of Palliative Care, University of Ottawa; Department of Palliative Medicine, Bruyère Continuing Care; and Palliative Care Service, The Ottawa Hospital, Ottawa, has stated, Despite those safeguards, more than 500 people in the Netherlands are euthanized involuntarily every year. In 2005, a total of 2410 deaths by euthanasia were reported, representing 1.7% of all deaths in the Netherlands. More than 560 people (0.4% of all deaths) were administered lethal substances without having given explicit consent. For every 5 people euthanized, 1 is euthanized without having given explicit consent. Attempts at bringing those cases to trial have failed, providing evidence that the judicial system has become more tolerant over time of such transgressions.
Dr Pereira has also found that despite supposed mandatory reporting of all acts of euthanasia in both The Netherlands and Holland, In Belgium, nearly half of all cases of euthanasia are not reported to the Federal Control and Evaluation Committee. Legal requirements were more frequently not met in unreported cases than in reported cases: a written request for euthanasia was more often absent (88% vs. 18%), physicians specialized in palliative care were consulted less often (55% vs. 98%), and the drugs were more often administered by a nurse (41% vs. 0%)... In the Netherlands, at least 20% of cases of euthanasia go unreported. That number is probably conservative because it represents only cases that can be traced; the actual number may be as high as 40%.

3. The circumstances under which euthanasia is applied tend to expand
It has been noted that in some jurisdictions where euthanasia is legally available, it has been administered to those outside the categories originally deemed eligible. Referred to as the slippery slope argument, those who oppose voluntary euthanasia claim that once it has been made legal for physicians to assist patients to end their lives the practice then tends to extend until it is used on those who have not requested euthanasia and who are not suffering an immediately fatal disease. In opposing euthanasia, former Australian Prime Minister Kevin Rudd has stated, If you changed the laws in this area, I do become

concerned about the way in which these things can drift over time.
This expansion of the terms under which euthanasia can be regarded as legitimate has been claimed to have occurred in The Netherlands. Critics note with concern the extension of euthanasia in to include disabled newborns and the non-terminally ill.
In July 1992, the Dutch Paediatric Association announced that it was issuing formal guidelines for killing severely handicapped neonates. Dr. Zier Versluys, chairman of the associations Working Group on Neonatal Ethics, said that Both for the parents and the children, an early death is better than life. Dr. Versluys also indicated that euthanasia is an integral part of good medical practice in relation to newborn babies. Doctors would judge if a babys quality of life is such that the baby should be killed.
In April 1993, a landmark Dutch court decision affirmed euthanasia for psychiatric reasons. The court found that psychiatrist Dr. Boudewijn Chabot was medically justified and followed established euthanasia guidelines in helping his physically healthy, but depressed, patient commit suicide. The patient, 50-year-old Hilly Bosscher, said she wanted to die after the deaths of her two children and the subsequent breakup of her marriage.
In The Netherlands euthanasia was originally proposed to be available at the request of the terminally ill, however, current guidelines have been expanded such that those who do not give explicit consent can be euthanised as can those who are not suffering from a terminal illness. Critics argue that euthanising those who have not requested the intervention is beyond any doctors professional prerogative while euthanising those without a terminal illness is simply assisting suicide.
Similar developments have also occurred in Belgium where initially euthanasia was only available at the request of competent adults suffering intolerable, incurable pain. Belgiums government has since tabled a new amendment to the laws that would allow euthanasia of children and Alzheimers sufferers. Thierry Giet, the countrys leader, has stated, The idea is to update the law to take better account of dramatic situations and extremely harrowing cases we must find a response to.
In July 2014, Australian euthanasia advocate Dr Philip Nitschke was suspended from practising medicine after he admitted to assisting a depressed, non-terminally ill 45-year-old man to end his life. Nitschkes actions have been condemned as demonstrating the distortions to established medical practice which are likely to occur were euthanasia to be made legal.

4. Palliative care can generally make pain tolerable
It has been claimed that good palliative care can generally relieve the pain of terminal illnesses such that euthanasia is not necessary to avoid physical distress.
In 1990, a World Health Organization (WHO) Expert Committee found that ...with the development of modern methods of palliative care, legalisation of euthanasia is unnecessary. Now that a practical alternative to death in pain exists, there should be concentrated efforts to implement programs of palliative care, rather than yielding to pressure for legal euthanasia.
British studies have indicated that no more than one to three percent of terminal cancer patients will present with pain that cannot be managed. In these few cases sedation is the preferred treatment.
Dr Pieter Admiraal, a leading advocate of voluntary euthanasia in the Netherlands, has stated that pain is never a legitimate reason for euthanasia because methods exist to relieve it, though these are not always available within his country.
It has also been claimed that most instances of severe depression associated with terminal illness are treatable. It is claimed that patients with clinical depression need appropriate treatment, not euthanasia in order to help them overcome their condition.
Further, critics of voluntary euthanasia are concerned that legalising this practice is likely to mean that inadequate resources will be directed toward alleviating pain and depression among the terminally ill.
It has been noted, for example, that palliative services in The Netherlands are not well developed. In 1988, the British Medical Association released the findings of a study on Dutch euthanasia conducted at the request of British right-to-die advocates. The study found that, in spite of the fact that medical care is provided to everyone in Holland, palliative care (comfort care) programs, with adequate pain control techniques and knowledge, were poorly developed. As of mid-1990, only two hospice programs were in

operation in all of Holland, and the services they provided were very limited. Dr Els Borst, the former Health Minister and Deputy Prime Minister of The Netherlands who guided the law through the Dutch parliament, said in December 2009 that she regretted that euthanasia was effectively destroying palliative care in her country.
The unanimous report of the British House of Lords Select Committee on Medical Ethics has recommended that there be no change to law in the United Kingdom to permit euthanasia. Rather, more and better palliative care was recommended.

5. Euthanasia places the physically, mentally, socially and economically vulnerable at risk
It has been claimed that voluntary euthanasia places those with any vulnerability particularly at risk. The concern is that those within these groups may be psychologically coerced into requesting that their lives be ended or, if they are not judged competent, the decision may actually be made for them.
In an article published in The Daily Mail Australia on October 7, 2014, it was noted that in The Netherlands in 2013, a total of 42 people with severe psychiatric problems were killed by lethal injection compared to 14 in 2012 and 13 in 2011. It was also noted that 97 people were euthanised by their doctors because they were suffering from dementia.
This concern about euthanasia being imposed on the vulnerable has been voiced by lobby groups for the disabled who see their members as particularly at risk. Among other things, these groups are concerned that disabled children will increasingly be killed at birth. Provisions to allow disabled newborns to be euthanised already exist in The Netherlands and there are philosophers and medical ethicists such as Peter Singer who argue that this practice should be available generally.
In his book, Practical Ethics, Peter Singer argues, At present parents can choose to keep or destroy their disabled offspring only if the disability happens to be detected during pregnancy. There is no logical basis for restricting parents' choice to these particular disabilities. If disabled newborn infants were not regarded as having a right to life until, say, a week or a month after birth it would allow parents, in consultation with their doctors, to choose on the basis of far greater knowledge of the infant's condition than is possible before birth.
Concern has also been expressed that in jurisdictions where universal health insurance is not available or where its terms are restricted, financial considerations may cause the poor to seek euthanasia or to be denied other treatments. Disability advocate Stella Young noted, Barbara Wagner, a 64-year-old Oregon woman diagnosed with terminal lung cancer, received a letter from her health insurance company saying that they were unable to pay for the chemotherapy she needed to treat her cancer, but they would cover the cost of physician-assisted death. [Physician-assisted suicide is legal in Oregon.] The same thing happened to Randy Stroup and presumably many others. In a health system stretched and cost-focussed, people are supported to die, but not to live.
In Australia there are currently discussions centred on reducing the availability of free health care. The cost of funding hospitals is also a recurrent issue. In these circumstances it could become possible that financial pressures lead to euthanasia.

Further implications
In the popular mind, euthanasia is normally seen as an act taken to end the suffering of a terminally ill patient at that persons request. That is the manner in which most opinion polls in Australia couch their questions when seeking to gauge public opinion on the question.
The real life experience of most proponents of euthanasia in Australia generally centres on having witnessed the distress of family members or friends who have died suffering conditions that were not fully responsive to palliative care. In circumstances such as these, euthanasia is not generally seen as suicide as the patient is in imminent likelihood of death. (In the US state of Oregon the law actually states that the patients death as a consequence of the medical condition being endured must be anticipated within the next six months.)
However, there are also those who are suffering from severely debilitating conditions which are not imminently fatal and yet result in dramatically reduced quality of life. In The Netherlands, for example,

those suffering intractable depression are eligible for euthanasia.
Once this category of patient is considered a candidate for euthanasia, as is the case in The Netherlands and Belgium, then the act is better termed physician-assisted suicide.
Before the question can be properly addressed in this country there needs to be clarification of what, if any, change to the law is actually being sought.
Suicide is no longer a crime in any Australian jurisdiction; however, that was not intended as a legal sanctioning of the act, rather as an acknowledgement that the law could take no meaningful action against someone who was dead and that criminalising suicide made it more difficult for the suicidal person to receive help. Assisting suicide remains a crime under Australian law.
If this continues to be the case, then Australian legislators can expect the terms of any euthanasia law passed in Australia that is similar to the Rights of the Terminally Ill Act to be challenged because it excludes those suffering from conditions which are severely debilitating but not immediately fatal.
Another complication of the euthanasia debate is that in both The Netherlands and Belgium, informed consent is no longer always required. In both jurisdictions it is possible to euthanise those suffering from dementia and Dutch statistics indicate that a significant number of those euthanised have not requested that their lives be ended.
Both these developments physician-assisted suicide of the non-terminally ill and euthanasia without consent are concerning. The first because it appears to pave the way for physician-assisted suicide on grounds determined solely by the patient and the second because it appears to give the power to determine when a life is worth living to the physician. We need an informed community-wide consensus on such profound issues.

Newspaper items used in the compilation of this issue outline

The Age: September 20, 2014, page 30, informative item (photos - ref to dying and to palliative care, plans for and attitudes to approaching death) by Miki Perkins, `One last summer' (see also page 10 for photo and item, `A life celebrated before long goodbye').
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The Age: November 14, 2014, page 16, interview with a palliative care nurse who is now himself terminally ill) by Konrad Marshall, `Into the darkness'.
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The Age: November 12, 2014, page 20, letters incl, `Change this capricious law for all our sakes / Anguish was heart-breaking'.
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The Age: November 11, 2014, page 16, investigation / interviews (photos) by Julie-Ann Davies, `Choosing an end to life'.
http://www.theage.com.au/comment/choosinganend

The Age: November 10, 2014, page 16, editorial, `Righting a travesty for the terminally ill'.
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The Age: November 22, 2014, page 35, comment by Suzy Freeman-Greene, `Some deaths aren't dignified'.
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