"Death talk": debating euthanasia and physician-assisted suicide in Australia

Somerville's article in the 17 February issue of the Journal, in which she argued that our understanding about euthanasia is being clouded by the use of imprecise language and deliberate confusion of ethical and legal concepts, has attracted strong opposition.

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TO THE EDITOR: Somerville argues that *Resolution 3* passed at the 2002 Australian Medical Association (AMA) Annual General Meeting "might inadvertently go well beyond" a position consistent with current ethics and law and might open a door to euthanasia.[1] *Resolution 3* states:

> . . . that the AMA support doctors whose primary intent is to relieve the suffering and distress of terminally ill patients in accordance with patients' wishes and interests, even though a foreseen secondary consequence is the hastening of death.

As the mover of this resolution, I wish to comment on Somerville's arguments.

Pain versus suffering: Somerville claims the phrase "to relieve their pain" does not open up the possibility of legitimating euthanasia, whereas "to relieve their suffering" does. She suggests better language would be "the relief of pain and other symptoms of serious *physical* distress of terminally ill patients".

This argument is weakened by the fact that powerful analgesics and adjuvant pain medications can be used for euthanasia, but the methods of palliating other suffering cannot so readily be used for this purpose.

Furthermore, the concept of purely physical pain has long been discredited. The dimensions of suffering cannot be neatly separated. Existential suffering can be just as agonising as physical discomfort, and there are moral and clinical imperatives to relieve all kinds of suffering.

Current law: *Resolution 3* is based on the "Care of the Dying" clause in the South Australian *Consent to Medical Treatment and Palliative Care Act 1995*. This clause codified the common law position. It was overwhelmingly supported in parliament — politicians believed terminally ill patients should not have to suffer pain and distress because clinicians feared prosecution for hastening death.

The Act and *Resolution 3* are fundamentally similar: both involve the principle of double effect, and both stipulate the need for patient-centred decision-making.

Patients' wishes and interests: Somerville is critical of the phrase "in accordance with patients' wishes and interests". She says it *justifies* rather than *excuses* life-shortening treatment: "an excuse carries the message that life-shortening is wrong . . . The message of a justification . . . is that the conduct of shortening life is right."

I believe it is better for a doctor to provide a valid justification than offer an excuse for a treatment that contributes to a patient's death. An excuse equates with an unsatisfactory attempt at explanation, whereas a valid justification implies ethical and appropriate care.

If a doctor aims to act in the patient's interests, and with the patient's informed consent, then the life-shortening consequences of an action may be accepted. The treatment, rather than the outcome, may be seen as "justified". Ethical care involves negotiation with the patient (or representative) to select the treatment that best suits the patient's wishes and interests.

Somerville apparently undervalues the principles of patient autonomy and informed consent, but these have a crucial role in medical decision-making. Decision-making about treatments that affect the time of death must be balanced between being doctor-centred and patient-centred.

Conclusion: *Resolution 3* is consistent with current ethics and law, and with relevant clinical concepts. If a medical treatment results in a patient's death then a valid justification, rather than an excuse, is required. This justification involves the careful consideration of, and respect for, the patient's wishes and interests.

1. Somerville MA. "Death talk": debating euthanasia and physician-assisted suicide in Australia. *Med J Aust* 2003; 178: 171-174. ❑

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TO THE EDITOR: Somerville's analysis of the Australian Medical Association's (AMA's) confusion in its recent resolutions concerning death and dying is helpful, but her subsequent anti-euthanasia arguments are inadequate.[1]

Somerville suggests that the AMA has moved closer to supporting euthanasia by adopting a neutral stance, because being neutral means the AMA has no principled reasons to oppose it. This is incorrect. Taking a neutral stance is to recognise that there are both good reasons to oppose an issue and good reasons to support it. In fact, a neutral stance remains more felicitous to the status quo, because it suggests that the AMA does not contemplate action in regard to the issue, but action is clearly required to legalise euthanasia.

Somerville distinguishes the right to have treatment withdrawn from the right to be killed, on the basis of the difference between death caused by the underlying illness, and death caused by a lethal injection. She states that there are "long-established, well understood, profound and important differences between allowing people to die, when it is ethically and legally justified, and making them die", and "respecting people's refusals of life-saving treatment belongs in the former category, euthanasia in the latter". It is difficult to assess what force Somerville thinks these assertions have. They do not constitute arguments for her position.

The only reason Somerville appears to offer is that acting with the primary intention of killing another person is inherently wrong, except in justified self-defence or defence of others, and this is a cornerstone of our law and

relationships. However, anything that is inherently wrong but admits exceptions is at least open to further argued exceptions. If there are cases in which assisting someone to die would be better than letting nature take its course (and many people believe there are such cases), then there is clearly a case for seriously questioning our "deep moral intuitions", rather than issuing infallible moral proclamations based on tradition.

Finally, while Somerville is correct in stating that doctors' secret involvement in euthanasia does not mean that it is right, she makes the stronger empirical suggestion that if doctors are presently ignoring the law against murder, we should expect them to disobey guidelines for voluntary euthanasia. This suggestion is no more than a rhetorical mischief, as doctors who ignore the current law are those who support euthanasia, and they would have no reason to disobey legal guidelines.

1. Somerville MA. "Death talk": debating euthanasia and physician-assisted suicide in Australia. *Med J Aust* 2003; 178: 171-174. ❑

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TO THE EDITOR: Somerville[1] says that language matters, which is why she selects the definition of euthanasia as "a deliberate act that causes death undertaken by one person with the primary intention of ending the life of another person, in order to relieve that person's suffering". This obviously produces a different response compared with the realistic definition (based on the classical understanding of the word) as "an act to cause a peaceful and dignified death on request", or the practical definition (that of the Voluntary Euthanasia Society of Victoria) as "an act, taken by, or at the request of, a rational informed person, whose intention is to relieve their intolerable suffering, by hastening their death in a dignified manner", which incorporates all the components of euthanasia in a medical context. Somerville provides a legal definition, which ignores the simple fact that the primary intention of an act of euthanasia is to relieve suffering — it is an act of palliation. The doctor involved has no desire to end life — that is the intention of the patient.

Somerville seems to choke on the word "voluntary", dismissing it in one sentence, despite the Australian Medical Association accepting, rightly, that doctors should respect "the patient's wishes and interests". She also, not surprisingly for a lawyer, recognises no suffering other than physical pain, ignoring dyspnoea, paralysis, cachexia, or psychological and existential suffering.

She claims, without any evidence, that allowing euthanasia would cause profound damage to society. The Netherlands have openly practised voluntary euthanasia for nearly 20 years, and the Swiss have allowed assisted suicide for 50 years[2] without any evidence of societal damage. Medically assisted suicide in Oregon (US) has been closely and officially documented over the past 5 years with positive effects on the use of hospice care, opioid use, and deaths at home rather than in hospital.[3]

Finally, how long must it take for this debate to focus more intently on physician-assisted suicide? Most patients who wish to relieve their suffering can do this for themselves, with the assistance of a physician for advice, support and prescription. This then places the responsibility for this fundamental decision and action where it should be, with the patient. It also minimises the small possibility of non-voluntary euthanasia. Just because the Dutch adopted direct lethal injection as their principal method of voluntary euthanasia does not mean that we in Australia should allow that method to dominate the debate.

Competing interests: R A S is President of the Voluntary Euthanasia Society of Victoria.

1. Somerville M. "Death talk": debating euthanasia and physician-assisted suicide in Australia. *Med J Aust* 2003; 178: 171-174.
2. Hurst SA, Mauron A. Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians. *BMJ* 2003; 326: 271-273.
3. Hedberg K, Hopkins D, Kohn M. Five years of legal physician-assisted suicide in Oregon. *N Engl J Med* 2003; 348: 961-964. ❑

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TO THE EDITOR: In endorsing the Australian Medical Association's (AMA's) reiteration of a negative policy on voluntary euthanasia, Somerville claims that "language is not neutral".[1] In discussing the wording of the resolutions, she argues for the term "suffering" to be subsumed within "pain and physical distress", even though "suffering" better reflects the complex physical and psychosocial dimensions of the human condition. This suggested white-out is troubling, but to be anticipated. Defending an unequivocal negative stance on euthanasia inevitably results in conditional compassion, for it must assume the right to control patients, instead of respecting their autonomy.

A negative policy has no more credence than a positive one. Neither represents the diversity of opinion that exists within the profession, or the broader community.[2]

A negative stance takes refuge in, instead of challenging, the problems imposed by the doctrine of double effect as public policy. Although this doctrine offers a (compromised) level of legal and emotional surety for the doctor, it takes no real account of other relevant moral considerations, or the views of the patient.

A policy stance which mirrors Somerville's view that "euthanasia is simplistic, wrong and a dangerous response to the complex reality of death" cannot respect the complexities arising from each person's very personal meanings and values attaching to life, death and

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There should be no more than 5 references. The reference list should not include anything that has not been published or accepted for publication. Reference details must be complete, including: names and initials for up to 4 authors, or 3 authors et al if there are more than 4 (see mja.com.au/public/information/uniform.html#refs for how to cite references other than journal articles).

dying. Its adherents must defend against acknowledging the true extent of suffering that some patients are forced to endure. A negative policy also fails to acknowledge that all end-of-life decision-making attracts moral evaluation, including "doing nothing", withdrawing futile treatment, or shortening life by symptom control.

Rightly or wrongly, the AMA's policy stance can also be interpreted as a way of absolving itself of any responsibility to face, let alone challenge, the legal and social circumstances under which medicine is practised — circumstances that inevitably lead to the "euthanasia underground" and the horrors of self-deliverance.[3]

Somerville's implication is that a negative policy stance based upon moral absolutism will resolve difficult moral dilemmas. It will not.

Competing interests: JM A is a member of a voluntary euthanasia society.

1. Somerville M. "Death talk": debating euthanasia and physician-assisted suicide in Australia. *Med J Aust* 2003; 178: 171-174.
2. South Australia Voluntary Euthanasia Society. Medical support for voluntary euthanasia. *VE Bulletin* 2002; 19(2). Available at: http://www.saves.asn.au/resources/newsletter/jul2002/index.htm (accessed May 2003).
3. Magnusson R. Angels of death: exploring the euthanasia underground. Melbourne: Melbourne University Press, 2002.

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TO THE EDITOR: Somerville discussed her perspectives on the debate concerning voluntary euthanasia which took place at the 2002 Australian Medical Association Annual General Meeting.[1] This debate arose because of submissions which sought the adoption of a neutral stance on this issue, similar to that taken on abortion.[2]

The voluntary euthanasia debate (including physician-assisted suicide) has intensified over the past 10 years, fuelled by enabling legislation in Switzerland, the Netherlands, Oregon (US), Belgium, and briefly in the Northern Territory, and by a groundswell of favourable public opinion. The arguments have been rehearsed countless times. Somerville's article adds nothing, but underlines the total failure of consensus. Her initial discussion on definitions and voting patterns seems pointless in the real world.

Public opinion polls have shown that more than 70% of Australians support the idea that terminally ill and severely suffering people should be free to make a choice,[3] and that palliative care is not always the answer. Some surveys of medical opinions, such as one within the Royal Australian College of Surgeons,[4] suggest most doctors probably agree, although many do not approve legalisation. These findings accord with my practice experiences, and contacts with colleagues, throughout a long surgical lifetime.

This indicates that voting at the conference did not reflect the opinion of most Australians, or a possible majority of our profession. Unfortunately, much of Somerville's article reads like a homily urging the negative view. Like her opponents, she claims the high moral ground, but opinions have clearly consolidated on the basis of previously accepted philosophical positions. In spite of the published studies, there is no clear and convincing knowledge of what percentage of Australian doctors approves voluntary euthanasia, whether legalised or not.

We need a well-conducted poll to determine an appropriate medical community stance on this issue, bearing in mind that community standards are now broadly accepted as the appropriate basis for legal sanctions on behaviour and practice.

1. Somerville MA. "Death talk": debating euthanasia and physician-assisted suicide in Australia. *Med J Aust* 2003: 178: 171-174.
2. Australian Medical Association policy and issues: medical ethics [website]. Available at: http://www.ama.com.au/web.nsf/topic/policy-medical-ethics (accessed June 2003).
3. Roy Morgan Research. Voluntary euthanasia survey — summary findings. 2002. Available at: http://www.vesv.org.au/pdffiles/roymorgan.pdf (accessed June 2003).
4. Douglas CD, Kerridge IH, Rainbird KJ, et al. The intention to hasten death: a survey of attitudes and practices of surgeons in Australia. *Med J Aust* 2001; 175: 511-515.

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TO THE EDITOR: I agree wholeheartedly with Somerville's closing statement "How a society treats its weakest, most in need, most vulnerable members best tests its moral and ethical tone".[1] Unfortunately, by preceding this with an argu-

ment against choice for euthanasia, Somerville effectively condemns those weakest and most vulnerable people who are suffering intolerably from a terminal illness to a horrendous existence.

A position statement by Palliative Care Australia acknowledges that, although pain and other symptoms can be alleviated, complete relief is not always possible, even with optimal palliative care.[2] The only relief from intractable pain and symptoms comes through death, and the present law perpetuates suffering by denying this release.

The moral and ethical tone of our society in this regard is shamefully weak. For too long, end-of-life decisions have centred on a doctor's stated intentions — "double effect". Somerville gives a lengthy justification of this doctrine and tells us that language and doctors' decisions about euthanasia are most important. Where do the needs of suffering people fit here?

The moral and legal validity of a doctor's action would be best determined by factors such as:

- the patient's right to self-determination and bodily integrity;
- the provision of informed consent;
- the absence of less harmful alternatives acceptable to the patient;
- the severity of the patient's suffering; and
- the requirement that a doctor should work always in the best interests of the patient.

Such a patient-focused approach will meet the needs of and protect all vulnerable people, thereby strengthening our society's moral and ethical tone with rationality and unconditional compassion.

1. Somerville MA. "Death talk": debating euthanasia and physician-assisted suicide in Australia. *Med J Aust* 2003: 178: 171-174.
2. Palliative Care Australia. Position statement on euthanasia. *Palliative Care News* 1999; (Autumn/Winter): 13. Available at: http://www.pallcare.org.au/newsletter/pdfs/Autumn99.pdf (accessed May 2003).

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In reply: Hunt seems not to understand the reason for distinguishing between life-shortening treatment to relieve pain and physical distress, and that to relieve suffering in general. Whether either type of treatment is likely to be used for euthanasia is beside the point. The doctrine of "double effect" can be used to justify life-shortening treatment to relieve pain, but not to relieve suffering in general. Moreover, if an intention of relieving suffering in general became a justification for giving life-shortening treatment, there would be no limits on using such treatment, that is, euthanasia would be legitimised.

I disagree that "there are moral and clinical *imperatives* to relieve *all kinds* of suffering" (emphasis added). Doctors, like the rest of us, should respond humanely to suffering people. But it is beyond the role of doctors and the mandate of medicine to assume an authority to kill people in the name of relief of suffering in general.

I agree with the position taken in the South Australian *Consent to Medical Treatment and Palliative Care Act 1995*, that patients should not have to suffer "pain or distress", but that is a narrower category than "suffering". Depending upon how the Act and *Resolution 3* are interpreted, they might or might not be "fundamentally similar". However, if interpreted to allow life-shortening treatment for the relief of suffering in general, then they go well beyond the accepted common law position on double effect.

Parker is wrong in stating that the Australian Medical Association (AMA) adopted a neutral stance; it expressly rejected doing so. However, his misunderstanding makes my point that the resolutions are inconsistent and confusing. He is also wrong to write that a neutral stance on euthanasia is morally neutral. It is not — it means that euthanasia is not morally wrong, which would contradict the AMA's current position.

One strategy for legalising euthanasia is to move incrementally towards its acceptance by using ambiguous or confusing language. Whatever Hunt's intention in drafting *Resolution 3*, it reflects those characteristics. Doctors need to be aware of that strategy.

Hunt appears to misunderstand the legal difference between justifications and excuses. These terms apply to the *consequences* of justified acts. Shortening life as a consequence of a justified treatment should only be excused.

Similarly, both Hunt and Syme do not seem to understand how informed consent functions in law and ethics. Consent is necessary but not sufficient to justify potentially life-shortening treatment. That treatment must also be not contrary to public policy. It meets this condition only if needed for pain or symptoms of physical distress.

Parker is dissatisfied with my statements on the distinction between killing and letting die. This distinction hinges on ethical and legal doctrines of causation and intention that are too complex to discuss here. There is a further distinction between intention and desire, which Syme confuses.

Anaf says I argue for "the term 'suffering' to be subsumed within 'pain and physical distress'". The fundamental point of my article is the absolute opposite. She appears equally confused on other points. One can only be for or against euthanasia, so "diversity of opinion" does not make sense here. Of course, all end-of-life decision-making attracts moral evaluation, but my article was not about all such decision-making.

Nommensen implies that "community standards" and "an appropriate medical community stance" necessarily equate to an ethically acceptable one. This is incorrect — majorities can decide to act unethically.

Contrary to Parker's final claim, there is evidence that many doctors in the Netherlands who support euthanasia do not follow the guidelines for carrying it out.[1] Similarly, experience in the Netherlands contradicts Coombe's assertion that legalising euthanasia will "protect all vulnerable people".[1] Some of the most vulnerable — mentally incompetent — people have been subject to euthanasia. The same source challenges Syme's statements on the Netherlands and Oregon (US).

Finally, Syme confuses the definition of euthanasia with the justification put forward by advocates of its legalisation. Creating such confusion can be a deliberate advocacy strategy.

1. Foley K, Hendin H, editors. The case against assisted suicide: for the right to end-of-life care. Baltimore: The Johns Hopkins University Press, 2002.