Euthanasia, Physician-Assisted Suicide and End of Life Care

Position Statement

BACKGROUND

1. As the peak medical professional society for the healthcare of and advocacy for older people, Euthanasia and End-of-Life Care is an issue the ANZSGM can expect to be asked to comment on or provide guidance to government bodies and healthcare organisations.

2. A number of other professional medical bodies have already adopted a position. As yet, the ANZSGM has not developed an official position on these important issues.

3. Legislation on the issues of Euthanasia and Physician-Assisted Suicide (PAS) has been introduced into many Australian jurisdictions (Northern Territory, South Australia, Western Australia and NSW) and also in New Zealand. On one occasion (NT, 1996), legislation was successfully passed and 4 people underwent euthanasia before the legislation was overturned by the Australian Parliament (1997).

4. It is likely that further legislation will be introduced. It is also true that euthanasia and PAS are relevant issues mainly for older people (given the prevalence of morbidity in the older age groups). The risk factors for non-voluntary or involuntary euthanasia in jurisdictions where euthanasia is allowed reflect the practice of geriatric medicine (patients >80 yo, non-Ca diagnosis, in-hospital deaths).

5. Some have suggested that, in view of point 4, the ANZSGM should have a position on the issue.

6. If the ANZSGM does agree to adopt a position, the aim of the position should be to advocate for and optimise care for older people in line with scientific and evidence-based principles. The aim should not primarily be to promote one particular philosophical viewpoint.

7. If the ANZSGM does adopt a position on the issues of Euthanasia and PAS, it must in doing so recognise that there is a diversity of views on the issue. The adoption of a position by the Society does not bind a member of the ANZSGM from holding a divergent view. As with adoption of all positions and policies, it does however recognise that there exists an overall view of the majority of members, and that the adoption of such a position represents the Society’s view on the optimal care of an older person. (For example, the position paper on

\[\text{1 CMAJ June 15, 2010}\]
Orthogeriatric care does not bind all members to agree that an orthogeriatric service is the only possible method of delivering good care to older patients with hip fractures, but instead represents the Society’s overall view that such a service is in the best interests of such patients.

8. Therefore, individual members of the Society might hold opposite personal views whilst still supporting the Society’s aims to advocate for what it considers the best care for older people. The Society respects the right of all members to hold their own views on any position paper or clinical issue.

9. The definitions should be agreed to ensure that misinformation does not occur. In particular, many people (even in the medical community) confuse the withdrawal of care in terminal disease or providing adequate palliative care as being equivalent with “slow euthanasia”. Dying with Dignity (the new name for the Voluntary Euthanasia Society) on their website state that “The palliative care movement is a business which has as it's (sic) core interest the extension of life (whether that matches the patients’ wishes or not)”. (DWD has now withdrawn this opinion from their website after the incorrect view on palliative care was pointed out to them). This demonstrates that many people, even those with genuine humane intentions, have limited understanding of palliative care and good medical practise.

10. For this reason, it is important that members of the Society have a clear understanding of the definitions.
   a. Euthanasia: An action which of itself and by intention causes a person’s death with the purpose of relieving suffering (actual or perceived).
   b. Physician-Assisted Suicide – as per above, but where a “physician” facilitates an individual’s act of self-euthanasia.
   c. Voluntary Euthanasia: Euthanasia requested by a cognitively-competent individual
   d. Involuntary Euthanasia: Euthanasia occurring where no request or consent is obtained and where the procedure is known to be against the person’s wishes.
   e. Non-voluntary Euthanasia: Euthanasia occurring where no request or consent is obtained and where the person’s wishes are unknown (e.g. in the case of reduced capacity, reduced consciousness or vegetative state.

11. Terms such as “active euthanasia” or “passive euthanasia” should be avoided because there is no meaningful difference scientifically or ethically.

12. Almost every scientific bodies and learned college that has looked into the issue has strongly advised against legislation to allow euthanasia or PAS. These include:
   a. The American Medical Association
   b. The Australian Medical Association
   c. The World Medical Association (194th WMA Council Session, April 2013)
   d. NZ RACP
   e. ANZSPM

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3 http://www.americanmedicalassociation.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion221.page
5 http://www.wma.net/en/30publications/10policies/e13b/
6 Euthanasia and Physician-Assisted Suicide: A Position Statement by the NZ Committee of the RACP, February 2013
13. Some arguments for euthanasia and PAS are based on the opinion that palliative care may not adequately control all end-of-life symptoms and that such symptoms can be managed with use of life-ending treatments. This implies that one can do whatever one wants with one’s life and that a person’s life may not be worth living (for whatever reason). This in turn means that:
   a. Human life is a good that can or should be ended by doctors (or others).
   b. There are (or could be developed) criteria to judge whether a person’s life is “not worth living”.
   c. A doctor can or should be involved in deliberately ending a life

14. Arguments against euthanasia and PAS include:
   a. Euthanasia would affect the patient-doctor relationship
   b. Methods to facilitate or bring about euthanasia would be taught in medical curricula and teaching hospitals
   c. The potential impact on patients (e.g. the exertion of undue influence on patients occupying hospital or aged care beds)
   d. The final decision for euthanasia would still be made by a doctor rather than by a patient
   e. Most situations in which euthanasia or PAS might be applied involve patients with limited capacity or autonomy
   f. Overseas experience has shown that in many jurisdictions, euthanasia has frequently occurred without express consent (up to 30% of all euthanasia/PAS events in some published studies)\(^8\), \(^9\), \(^10\)

15. Given that euthanasia is likely to principally be an issue for older people and given that most other scientific and learned bodies have a position statement on the issue, it seems incongruous that the ANZSGM would not have a position on the issue.

16. In view of the position of our learned colleagues, the concerns over abuses seen in overseas jurisdictions and that our focus should be on optimising access to palliative care services and promoting the practice of good medical care for older people, the most logical position for the ANZSGM would be to adopt a position opposed to the introduction of euthanasia or PAS in Australia and New Zealand.

17. Some members have expressed concerns about the ANZSGM adopting such a position. A few members who spoke at the 2011 AGM when the issue was first raised expressed the concern that the Society’s adoption of a position contrary to their own individual views might put some members in an untenable situation. The opinion of these members should be respected, even if the Society adopts a position. It is important that if the Society adopts a position, it does so using the most inclusive language possible, so as to ensure that all members continue to feel part of the Society. The Society should respect the right of all

\(^7\) http://www.anzspm.org.au/c/anzspm/?a=da&did=1005077
\(^8\) Remmelink Report (Dutch Govt, 1991)
\(^9\) NEJM May 10, 2007
\(^10\) CMAJ June 15, 2010
members to hold their own views based on their own principles and values (even if such views do not reflect the views of the Society as a whole).

18. The Society could achieve this by adopting a position using language similar to that of our learned colleagues. This could be expressed in the following terms:

**POSITION STATEMENT OF THE ANZSGM**

The ANZSGM acknowledges the wide range of perspectives and ethical views amongst geriatricians in Australia and New Zealand on euthanasia and physician-assisted suicide. Some members hold differing views in good faith and the views of all members are respected and ongoing discussion is encouraged. However, it is the position of the ANZSGM that:

1. The ANZSGM supports the views of the ANZSPM, the AMA, the WMA and the RACP (NZ) on the issues of euthanasia and physician-assisted suicide (PAS). In doing so, the Society opposes legislation which would allow euthanasia or PAS.
2. The Society maintains that euthanasia and physician-assisted suicide are not part of palliative care practice (in accordance with the Australia and New Zealand Society of Palliative Medicine’s position statement).
3. The Society supports older patients’ rights to refuse or discontinue burdensome or futile treatment.
4. The Society supports a dying older person’s rights to a death characterised by dignity, adequate symptom control and optimal access to expert palliative care management. Similarly, medical treatments should not solely focus on prolongation of life.
5. Whilst recognising that not all symptoms will be successfully abolished, the Society’s view is that policy makers and funders of health care can best help patients by ensuring adequate provision and funding of high-quality palliative care and geriatric medicine services, rather than by providing legislation allowing euthanasia.
6. The Society is deeply concerned about the potential consequences of legalising euthanasia and/or physician-assisted suicide in New Zealand and Australia. Key concerns include:
   a. Portraying a conflicting public health message, i.e. that suicide is the preferred option in certain circumstances
   b. Placing pressures on frail aged patients who may feel they are ‘a burden’ on others. Such feelings are often due to underlying depression, financial concerns or family dynamics.
   c. The risks of involuntary or non-voluntary euthanasia in patients with cognitive impairment, dementia or reduced capacity.
   d. Adverse effects on the funding for palliative care services and research
   e. Changing the concept of doctors being ‘treaters’, ‘life savers’ and ‘healers’ to being providers of life-ending services, and the impact this may have on patient-doctor relationships.
   f. Increasing justifications for euthanasia and potential for abuse, for example cost savings for the health system

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