Euthanasia and Physician Assisted Suicide

Position Statement

Preamble
At the date of release of this position statement, the practices of euthanasia and physician assisted suicide are illegal in Australia.

Palliative Care Australia (PCA) is the national peak body for palliative care. We provide leadership on palliative care policy and community engagement in Australia. Working closely with consumers, our Member and Affiliate Member Organisations and the palliative care and broader health workforce, we aim to improve the quality of life and death for people living with life-limiting illnesses and their families and carers.

Internationally, legalisation of Euthanasia and Physician Assisted Suicide are two frequently debated issues that are seen as important matters for society to consider. The issues are highly complex and raise significant ethical issues. PCA acknowledges that there is a broad spectrum of opinion and a level of support for reform within the Australian community reflecting diverse cultures, belief systems and populations. We also recognize that some competent people may elect to request euthanasia or physician assisted suicide.

Palliative Care Australia believes:

- The practice of palliative care does not include euthanasia or physician assisted suicide.
- The World Health Organisation recognises that palliative care does not intend to hasten or postpone death.¹
- Every Australian living with a life limiting illness should have timely and equitable access to quality, evidence-based palliative care and end-of-life care based on needs².
- There is clear evidence of the benefits of timely access to palliative care and end-of-life care for persons, family carers and the health care system.²,³,⁴,⁵,⁶
- The main goals of palliative care and end-of-life care are symptom relief, the prevention of suffering and improvement of quality of life. Palliative care and end-of-life care are person-centred and focused on individual and family needs.
- Compassion, dignity, respect and participation in decision-making are important to all and integral to delivery of high quality palliative care and end-of-life care. A request for euthanasia or physician assisted suicide requires a respectful and compassionate response.
When aligned with persons’ wishes, withdrawing or refusing life sustaining treatment (including withholding artificial hydration) or providing medication to relieve suffering, do not constitute euthanasia.

**Palliative Care Australia calls for:**

1. **Improved access to palliative and end of life care in all settings across Australia that is adequately funded.**

   **WHY:** There is significant unmet need for high quality palliative and end of life care and forecasts indicate significant increases in need in the years ahead. 

2. **Improved access to timely, appropriate and adequate support for family carers.**

   **WHY:** Support for family carers (including information, training, respite, practical help, emotional, social, financial and bereavement support) is essential to promote the wellbeing of family carers and to enable them to sustain the caregiving role. Comprehensive support for family carers can reassure people receiving care that their families are being supported.

3. **A fully resourced and sustained national public awareness and engagement strategy about palliative care and end-of-life care, death and dying so that the broad range of issues can be explored in an inclusive and constructive manner.**

   **WHY:** There are many misconceptions in the community and amongst some health professionals about life limiting illness and palliative and end of life care. In order to engage in constructive deliberations about euthanasia and physician assisted suicide Australians need access to accurate information about palliative and end of life care issues. Palliative care and end-of-life care are often inappropriately thought of as the natural opponent of pro-euthanasia advocates; the polarising nature of this perspective is not helpful and should be avoided.

4. **An adequately resourced and appropriately trained health workforce to engage in respectful dialogue with people about end of life wishes in a way that allows time to explore the social, cultural, spiritual, emotional and physical aspects of their care decisions.**

   **WHY:** Whilst requests for euthanasia and physician assisted suicide are few in number, people expressing these wishes must be supported in a way that allows time for full exploration of their concerns. Currently, however the majority of health care professionals in Australia have not undergone formal training in communication skills, advance care planning conversations or effective strategies to respond to the needs of persons and their family and carers affected by life limiting illnesses.
5. Informed choice and participation in decision-making about goals of care and treatment must be an integral part of all health and care services across Australia.

**WHY:** Australia needs nationally consistent laws at the end of life including, in particular, guardianship laws that govern the appointment of substituted decision-makers and their powers to refuse treatment and laws governing advance directives. Australia also needs a nationally consistent approach to advance care planning, where laws and options provided to people with life limiting illness must be made widely known and fully integrated into all health care.

The benefits and harms of any treatment (including the provision of medically assisted nutrition and hydration), should be considered before commencing such treatments and reviewed regularly. People receiving care that is aimed at management of symptoms must be informed and be able to exercise choice in the receipt of that care.

6. Public discussion and policy development on issues related to euthanasia and physician assisted suicide should be informed by research.

- **WHY:** There is insufficient research into euthanasia and physician assisted suicide. A national research strategy is required to build the evidence so that Australians can receive best care tailored to their individual needs.

**Definitions:**

**Palliative care:** as defined by the World Health Organisation\(^1\) is an approach that improves the quality of life of people and their families facing the problems associated with life-limiting illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative provides relief from pain and other distressing symptoms; it

- affirms life and regards dying as a normal process;
- intends to neither hasten nor postpone death;
- integrates the psychological and spiritual aspects of the persons care;
- offers a support system to help people live as actively as possible until death;
- offers a support system to help the family cope during the person’s illness and in their own bereavement;
- uses a team approach to address the needs of people and their families, including bereavement counselling, if indicated;
- enhances quality of life, and may also positively influence the course of illness; and
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

**Life-limiting illness:** The term life-limiting illness is used to describe illnesses where it is expected that death will be a direct consequence of the specified illness. Such illnesses may include, but are not limited to:
• cancer
• progressive non-malignant diseases including dementia
• life-limiting diseases of childhood

End of life care: includes physical, spiritual and psychosocial assessment, and care and treatment delivered by health professionals and ancillary staff. It also includes support of families and carers, and care of the person’s body after their death. People are ‘approaching the end of life’ when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

• advanced, progressive, incurable conditions
• general frailty and co-existing conditions that mean that they are expected to die within 12 months
• existing conditions, if they are at risk of dying from a sudden acute crisis in their condition
• life-threatening acute conditions caused by sudden catastrophic events

Euthanasia: a physician (or other person) intentionally killing a person by the administration of drugs, at that person’s voluntary and competent request.

Physician Assisted Suicide: a physician intentionally helping a person to terminate his or her life by providing drugs for self-administration, at that person’s voluntary and competent request.
References: