13 July 2015

Inquiry Into End of Life Choices

I welcome this opportunity to contribute to the above inquiry. I write as an elderly person with a disabled wife and a nephew who took his own life. My wife and I have witnessed the final days and weeks of family members and others, and we do not want to experience the suffering they endured. We have made Advance Directives which set out our end of life requirements, and would appreciate the law be changed to ensure they are legally enforceable.

It is well established in public opinion polls that voluntary euthanasia (V.E.) has the overwhelming support of the public (around 80%). In a democratically elected government, parliamentary representatives have a responsibility to carry out the wishes of the public, unless:

(a) minority interests need protection, or

(b) the public is completely misguided.

With regard to (a), the minority (those opposed to V.E.) are protected by the voluntary provisions. With regard to (b), I do not believe those in favour of V.E. are misguided (although many tend to understate the need for adequate safeguards – and these are crucial). Their case studies speak for themselves.

In contrast, from my reading of the opposition to V.E. (in previous inquiries and the media), much of it I

believe is arrogant, illogical, superficial, exaggerated, condescending, uncaring or reeking of religious bigotry.

The case for voluntary euthanasia (and assisted suicide) is based on the moral principle of helping others in distress, a principle that should have the support of all who believe in Christian compassion – or any other form of compassion. The only debatable issue is the difficulty of designing appropriate safeguards to ensure that V.E. is not misused, abused or misunderstood. **It is these safeguards that should be the centre of debate.**

It should not be beyond the wit of the human mind to come up with structures and procedures that provide satisfactory safeguards that would protect some, if not all, persons in distress. I can discern four different types of situations that might arise, all justifying euthanasia or assisted suicide but requiring different safeguards.

(1) The first is where the patient prepares a **written request** for the termination of life. This document should be signed by the patient, properly witnessed and supported by appropriate medical certification (e.g. of sound mind and judgement, terminally ill and incurable, and has explored all available palliative treatment). One of the witnesses could be a public official (e.g. the Public Advocate), who would record the request in a public register and should also be present when the final treatment is given.

(2) The second situation is where a request for termination of life can be **verbally expressed**, but it is too late to satisfy the requirements of a formal written request. An example would be an accident victim who cannot be saved, but is facing the prospect of an

agonising death, e.g. crushed under a heavy vehicle or machine. Safeguards in this situation would be more difficult to design and would need to be more flexible. One option could be to make use of voice recording.

(3) The third situation is where the patient is unable to express a rational desire, either written or verbal, and is otherwise **unable to communicate**, but has prepared in advance a written set of instructions containing the conditions under which life is to be terminated, such as an "**Advanced Directive**" that is in common use at present in Victoria for the removal of life support systems as allowed under the Medical Treatment Act. An example would be a person suffering from Alzheimers or Stroke or who is in a vegetative state as a result of accident.

In this situation, the personal representative (Medical Power of Attorney, family member, etc.) would have authority to act - in accordance with the instructions contained in the Advanced Directive.

The existence of an Advanced Directive could also be useful evidence to support action under situations (1) and (2) above, especially (2).

(4) The fourth situation is similar to (3) but the patient has *not* prepared an Advanced Directive. In this situation, safeguards would be even more difficult and less satisfactory, as the decision would be **involuntary** and would rest with family members, doctors and others (e.g. Courts or persons holding Medical Power of Attorney). Doctors are often faced with these difficult decisions, and Courts may have to give judgement if family members disagree, as in the much publicised Terri Schiavo case in the USA in 2005.

In **summary**, a cautious approach might be to legislate for situations (1), (2) and (3), but in a way

that does not discourage or limit current practice where members of the medical profession exercise discretion and humane judgement as may be required in situation (4). If, however, suitable safeguards can be devised for situation (4) then legislation for that could also be considered (in conjunction with the Medical Treatment Act if the patient is on life support).

The alternative to properly legislated euthanasia and assisted suicide is intolerable suffering by patients, or suicide carried out without medical supervision, as was the case of my nephew.

Some Popular Misconceptions

1. **Life is sacred** and should be preserved at all times. Is it rational and moral to believe in the right to life but not the right to end life? We have no say in our parents' decision to give us life, but if we subsequently believe that decision was a mistake (e.g. we are born disabled as in my nephew's case) or no longer valid, (e.g. when incurable cancer strikes) should we not have the right to reverse that mistake by ending our life? To refuse us that right is merely compounding the injustice!

   "Life is sacred" is a spiritual rather than a moral argument. If it is to be taken seriously, the onus is on its proponents to prove, by scientific medical evidence, that they have superior judgement regarding the life aspirations of patients than do the patients themselves. An impossible task, except possibly in situation (4) above, in which case it provides an argument *for* euthanasia!
2. Involuntary euthanasia of suffering **animals** is justified, but voluntary euthanasia of suffering humans is not. A curious anomaly; is the life of

animals inferior, superior, or equal to that of humans?

3. V.E. can become a **slippery slope** to more extreme forms of life extinction and place vulnerable groups at risk. The important thing here is to ensure that good, rational and humane decisions are made at all times. If A leads to B, then provided both A and B are rational and humane, the slippery slope is *desirable*. But if A and/or B are *not* rational and humane, they should not be implemented. Are politicians incapable of designing good policy structures to ensure this is so?
4. We could end up with a situation similar to **Nazi Germany** where euthanasia was widely abused. But the Nazi experience was not voluntary, not framed in a democratic environment, not subject to proper safeguards and not based on moral principle.
5. **Palliative care** can ease suffering and therefore V.E. is unnecessary. It is unlikely that a person would opt for V.E. if the suffering could be satisfactorily eased by palliative care. Unfortunately, some people do not respond to palliative care; e.g. may be allergic to morphine and other pain killing medications, as is the case of my wife. But if the medical profession is not making sufficient use of palliative care, then that needs to be addressed.

   Two of the patients I visited in their final weeks confided in me they were scared. Euthanasia can be a taboo subject in these circumstances, but I knew that an important form of palliation (but not legally available to them) would have been the knowledge that a peaceful pill would be available if required.

6. People in suffering need the **support of family and friends**, not termination of life. Support certainly is needed, but more than that may be necessary if the suffering is intolerable. Why close off the option of termination if that is the patient's clearly expressed desire?
7. The patient does not want to be a **burden on the family**. People often make sacrifices for the sake of others. It is one of the most noble and morally uplifting actions one can take. Why deprive them of that sacrifice if it is their final wish?
8. The patient may be **pressured by relatives** and others motivated by greed. Survival is a very strong natural instinct, so I imagine very few patients would respond to such pressure. But in so far as the risk is there, it is the responsibility of witnesses and doctors who are party to a written request to ensure that the patient is acting independently and expressing a genuinely voluntary desire, free of coercion. This is where a public official can play an important role (see situation (1) above).
9. A patient may over-react due to **depression**, not knowing it (the depression) can be cured. One of the tasks of the certifying doctors would be to ensure that the patient is mentally competent to make a rational decision, and that all anti-depressant treatments have been exhausted (medications, E.C.T., counselling, etc.). I had a relative who suffered from severe depression and was seriously contemplating suicide, but saved by E.C.T. The result could have been different; he could have suicided, but had the option of legalised V.E. been available he would have been better counselled.

10. **Errors of diagnosis and prognosis** can be made. Patients should factor this risk into their decision, as should their counsellors and doctors, and err on the side of caution if time is on their side. But if the suffering is intolerable and the patient does not want to wait - in the off-chance that he/she may recover, the rational decision might be to go.
11. V.E. may be requested because it is **cheaper than medical treatment**. This argument may have relevance in countries that do not have universal health insurance, but even there it is a nonsense argument. If a patient has only three options; i.e. treatment, V.E. or intolerable pain, and the first option is unattainable, why take away the second option also?
12. V.E. is contrary to the teachings of the **Bible**. No rational analysis of a complex medical and moral issue should be based on a historical document which is neither the only, nor the best, source of moral wisdom.
13. Doctors should abide by the **Hippocratic Oath** – to save life, not end it. Doctors who swear to this Oath display an unthinking, uncritical attitude, unworthy of an intelligent, educated profession. It is similar in principle, if not in magnitude, to Nazis swearing allegiance to Hitler and claiming exemption from blame for their actions because they were answerable to a higher authority.
14. V.E. will worsen **doctor-patient relationships** and create a culture of death amongst doctors. If proper safeguards are devised, doctors should not be required to practice V.E. if they have objections to it. This could be the province of specialists, as was the case in the Northern Territory.
15. A patient might express a desire to end life, but

subsequently **change his/her mind** and want to live. If the patient has decided to battle on, why would he/she request to be put down?

Concluding Comments

It has been argued (e.g. in The Age, 27/5/2015) that no satisfactory safe guidelines are possible and therefore the risks of legalising assisted suicide (or V.E.) are too great. This I believe is a gross exaggeration. There could be risks, but that can be said of most medical treatments. When the suffering is severe we may be prepared to take the risk. That is a decision for the patient or his/her personal representatives, not for the legislature.

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