

# End of Life Choices submission.

Dr Rod Stephenson, [REDACTED].

## Introduction

I am a general medical practitioner practicing almost solely in aged care. I look after many patients towards the end of their life and have input into the advanced care planning of most of these. I find it exciting to be able to offer what I can for them when they are approaching this stage in their life.

The contents of my submission are not new but I have put this submission forward in the hope that there is never any need for allowing euthanasia but instead we can provide a framework that will reflect how we can properly care for our elders.

## Suffering

Making choices at the end of life is mainly about choosing what to do with our suffering. This is not only the suffering of the patient but also the suffering of those who care for them.

No suffering is easy but not all suffering is bad. I may suffer that my foot hurts when I have a stone in my boot. I could react in two ways. I could take the stone out of my boot and the pain would gradually subside or I could leave the stone there but take pain killers. Most of us would choose the easier and more sensible option. Note here that pain is a good thing in that it warns us of danger. Suffering can also teach us to do things differently in the future.

As medical practitioners we spend our career preventing suffering or reducing suffering. It is programmed into everything we do. Most patients come requesting that we treat their suffering. Sometimes we are unable to and I think this really grates on our nerves. An easy option such as euthanasia could be pleasing to many as the suffering seems to be easily treated.

## Euthanasia definition

Euthanasia or assisted suicide :

- actively seeking to end the life of another person at their request – which may either be an advanced directive or at the time.

Please note that this definition does not include

- circumstances where people elect to withdraw life saving treatment either because they have had enough or because the treatment is futile anyway.
- circumstances where the side effect of appropriate symptom control results in end of life.

## Definition confusion

- I note that a lot of surveys confuse the issue of the above definition. Most patients I encounter do not understand the difference between withdrawing life saving treatment and assisted suicide and cannot be expected to correctly state their wishes either on a survey or when they are making their wishes known unless this is understood.
- Unless the definition is properly understood, it is difficult to have a proper public discussion of the issues.

## The Easy Option

Our bible says that “Man is made in the image of God” and that “You shall not kill”

I can understand why these two statements were made. We seem to be inherently selfish and rather than empathising, it would be very easy in an argument to just pull out a club, knife or gun and end the discussion by

killing the other and ensuring that you have won the battle. To me it seems obvious that there would be little left of society if this was allowed to happen. We need a rule that says “You shall not Kill”

The first statement is to make us realise that not only are we important to God as we are made in his likeness but we are also equal in value. In Germany in the Second World War there was genocide based on the assumption that one race was superior to another. It is easy to see in hindsight that this was a badly mistaken assumption.

I believe that euthanasia is a wrong and dangerous choice and while it may seem wise at the present, we will look back on it in horror.

Euthanasia can become a very easy option.

- Emotionally easy - I see many families seeing their loved ones suffering and wishing it would end for them. This can happen even when the patient is happy in their suffering but very much so when they are not.
- Fiscally easy – No more expensive or continual treatment in nursing homes or at home where the patient is dependent on a variety of helping professions. No more high hospital costs when they deteriorate.

## Alleviating end of life suffering.

There are always alternatives to euthanasia. They are not always easy.

Palliative care as a discipline did not commence all that long ago. It is an interesting observation that now that we have far better medications to alleviate the pain and suffering that we should even be looking at legalising euthanasia.

Fortunately where I work, there is good access to palliative care.

## A very real slippery slope.

Currently, euthanasia is not permissible yet because of some of the factors I mentioned above, it still happens even though it is illegal.

If ever there is legislation to allow euthanasia, I know that it won't stop there. It is all too easy to give excessive medication with the express purpose of ending life without consent or choice. I have already had many families request this. The pressure for this to happen is already present.

Any legislation that is enacted that will allow the killing of consenting patients, cannot possibly prevent the killing of non-consenting patients. I would even suggest that it will encourage non-consenting killing as either doctors, carers or families see it as an easy way out.

## The devaluing of life

The other real danger is that if euthanasia becomes acceptable, there will be pressure on the elderly to request it. Families may put pressure on patients either knowingly or unknowingly to request euthanasia.

There will also be a societal pressure. I know this will be real as during one pregnancy of ours we had a scan that suggested Downs syndrome and were dismissed by the doctor when we didn't want further testing as we were not going to end the pregnancy anyway. Fortunately the diagnosis was wrong. It would be easy to see the reaction of others to a downs syndrome baby when we were burdened by the tasks of looking after the baby – it is your own fault that you are overburdened, you could have had the baby aborted!!.

The burden of looking after aged relatives increases towards their end of life. Very few patients want to be in nursing homes anyway. How easy it would be to offer euthanasia instead of looking to see how we could improve their life while they had a disability.

## Advanced care directives

Unfortunately, I see many patients who have Advanced Care Directives that change their mind. It is one thing to have a directive when you are remotely removed from a situation eg, years before some incident happens, but quite another to say that you are not going to have treatment after an incident happens.

Advanced care plans where an outline of wishes in certain circumstances is far more appropriate and can be dynamically changed depending on the incidents and associated illnesses. Sometimes medical treatments that worked 6 months ago can become futile when diseases progress. This approach is not as easy as we need to be continually checking with patients and families as new problems develop (which is after all good Primary Health Care). It does however reflect where patients and families are at the present time.

At present there seems to be little support for general practitioners to become involved in advanced care planning. I am fortunate to have a team that includes a doctor who does this for the patients who come under my care. Not many doctors or facilities are as fortunate. There is little support from the public hospital system and I find that it is often the less experienced doctors in hospitals who are called to discuss these issues with the patients and families. It may be that a few extra resources in this area will reduce the amount of times futile treatments are requested. I would suggest that these services are provided at the request of the patient's general practitioner who can also be involved in the discussion. A consideration of a specific medicare item number may encourage more general practitioners to become involved.

## Palliative care

Current palliative care services in the South Eastern Melbourne area are mostly adequate. There is a palliative care service which is prompt and sees patients in the nursing home who are dying. They are also very supportive for families. Sometimes though there are situations where it becomes difficult to control symptoms where inpatient palliative care services are required. From my perspective, it is often difficult to access these inpatient services.

## Withdrawal of treatment

In the aged care setting, there are many treatments that become futile. An example of this might be to do a cardiac bypass in someone whose kidneys are also failing. Doing the bypass may fix one problem but will not improve the overall health and wellbeing of patients. Some families and patients still request treatments that may be futile. Under the current legislative framework, if the patient or power of attorney request to be sent back to hospital for further treatment, we are often obliged to do this. The alternative is to spend time with patients discussing the advanced care plan.

## Preventing patient anxiety

If there is a scenario where euthanasia is legislated, then it would lead understandably to anxiety in elderly patients who do go into hospital where someone may view their life as not worth living.

I would suggest if this is ever legislated that there be registered euthanasing doctors. Patients would then know which doctors were available and could then go to different non euthanasing doctors and hospitals where they would know that their life was considered to be worthwhile.

## Coercion

I think it is also wrong to coerce health professionals into providing services that they do not want to provide. I say this as this has been what has happened in the abortion legislation. I am of the view that I offer good services to any patients under my care but if there is coercive legislation to offer euthanasia, I will have 2 choices, to shun the law or stop providing any aged care services.

## Conclusion

I would hope that you will come to the conclusion as I have, that any end of life choices legislation that allows euthanasia as part of it is not in the best interests of either the patients or society as a whole. There are good alternatives in palliative care and we should be supporting these. Regardless of the pressure of minority groups, I would also ask that any legislation that allows euthanasia be rejected.