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To: LSIC
Subject: Inquiry into End of Life Choices - Legal and Social Issues Committee

Inquiry into End of Life Choices - Legal and Social Issues Committee Submission by Peter C Murray.

The term “Dying with Dignity” is a euphemistic slogan whose real purpose is to mask the call for the intentional killing (euthanasia) by doctors and nurses of persons/ patients requesting their lives be ended. As such the term is deceptive and creates confusion particularly amongst the vulnerable and results in the loss of control and autonomy over patients’ lives.

In the Netherlands, an increasing number of patients with psychiatric illnesses or dementia are euthanized by their doctors at an alarming rate. Euthanasia is on its way to becoming a ‘default’ mode of dying for cancer patients (T Boer, Dutch ethicist: “Assisted suicide: don’t go there, July 26, 2014)

In Belgium last year a pair of middle-aged deaf twins, who were not terminally ill, were legally euthanized – they were injected with lethal poison by their doctors (Daily Mail, January 15, 2013). Belgium has now even legalised the euthanasia of children of any age (Daily Mail, Feb 13, 2014)! Euthanasia of people with Alzheimer’s disease is currently being debated in Belgium.

In particular euthanasia creates dangerous scope for abuse of the elderly. The organisation called Australia’s Elder Abuse Prevention Association has estimated that there are a minimum of 100,000 cases in Australia each year where the elderly have been victims of manipulation, control, intimidation and fear. In such cases, the elderly can feel too powerless to defend their lives and their property.

Another factor to be considered is the effect on the medical profession whose medical associations are opposed to euthanasia – legalizing euthanasia would infringe on the conscience of the vast majority of doctors and medical staff.

Palliative care services are the counter to calls for euthanasia. Palliative care should not be corrupted by legalising assisted suicide/euthanasia. However, there is scope for improvements in palliative care services particularly in regional areas.

The Australian and New Zealand Society of Palliative Medicine says that 1.0 full time equivalent (FTE) palliative medicine specialist per 100,000 people is the minimum ratio for a reasonable provision of service. Palliative Care Australia

recommends palliative care specialists should be provided to the level of 1.5 FTEs per 100,000 people. Yet the Australian Institute of Public Welfare 2013 report on palliative care services in Australia (see <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129545131> Table 7.3) found that nationally, in 2011, the average ratio of FTE palliative care specialists per 100,000 people was only 0.4. And it varied from state to state and between the city and regional areas. In major cities access was at 0.5 while in outer regional areas it was 0.3 and an even lower 0.2 in inner regional areas (see Table 7.4).

Experts in end of life services and aged care such as Professor Colleen Cartwright^[1] testify to the effectiveness of palliative care in the vast majority of cases, but stress the need for improved training of doctors and medical staff especially in pain management. This is a significant social justice issue that needs to be addressed so that every Australian has access to a palliative care specialist to an acceptable standard and on an equitable basis.

Legalising euthanasia or assisted suicide would undermine palliative care. It would affect the amount of investment of resources in improvements to palliative care if the seemingly easier and cheaper option of euthanasia or assisted suicide were legally available.

To quote Paul Russell, Director of the organisation HOPE, Preventing Euthanasia and Suicide: <http://noeuthanasia.org.au/blog/1856-the-arbitrary-nature-of-euthanasia-safeguards.html>) “This all points to another reality: that the existence of euthanasia laws creates deep and almost indelible changes to any society where it is legally practiced. What is legal is moral. The law provides boundaries that human nature pushes against almost constantly. Move those boundaries to accommodate the push and, inevitably over time, the push will come against the newly defined boundary. This is the human experience and why, until relatively recently, all societies resisted such changes.”

Advanced Care Directives should be descriptive, rather than prescriptive. They would be better called *Advance Care Plans*, which focuses on what is *planned* rather than setting in writing a legally enforceable directive that a person does not want specified medical care/treatment if a specified health issue arises. As an illness or as age advances a person’s experience of reduced mobility and reduced ability to engage or to deal with the illness or frailness may very well change and they may not make the same decision about refusing medical care/treatment they did when making the ACD.

Killing (euthanasia) in medical settings is a dangerous across-the-board ‘healthcare’ policy. It establishes a precedent that will result in a loss of personal choice, render hospitals unsafe places and threaten the lives of people who are deemed an

“economic burden”. To this end, our own lives and our own healthcare is at stake if we remain unconcerned about the euthanasia agenda being propagated in our society.

Accordingly, the committee should reject calls to legalise euthanasia/assisted suicide and advocate much improved funding of palliative care and training of palliative care health workers.

Yours sincerely,
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^[1] <http://www.abc.net.au/local/stories/2010/09/16/3013535.htm?site=brisbane>