

Submission

for the

Inquiry into End of Life Choices

to the

Legal and Social Issues Committee

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Table of Contents

1. Introduction	1
2. Terms of reference	1
3. Palliative care	1
4. Euthanasia and assisted suicide	2
4.1. <i>Definitions</i>	2
4.2. <i>Issues</i>	3
4.3. <i>Summary</i>	5
5. Conclusion.....	6
6. Endnotes	6

1. Introduction

On 7 May 2015, the Legislative Council agreed to a motion requiring the Legal and Social Issues Committee to “inquire into, consider and report, no later than 31 May 2016, on the need for laws in Victoria to allow citizens to make informed decisions regarding their own end of life choices.”

FamilyVoice Australia is a national Christian voice, promoting true family values for the benefit of all Australians. Our vision is to see strong families at the heart of a healthy society: where marriage is honoured, human life is respected, families can flourish, Australia’s Christian heritage is valued, and fundamental freedoms are enjoyed.

We work with people from all major Christian denominations. We engage with parliamentarians of all political persuasions and are independent of all political parties. We have full-time FamilyVoice representatives in all states.

Submissions are due on the revised date of 31 August 2015.

2. Terms of reference

The Legal and Social Issues Committee is to inquire into, consider and report, no later than 31 May 2016, on the need for laws in Victoria to allow citizens to make informed decisions regarding their own end of life choices and, in particular, the Committee should —

- (1) assess the practices currently being utilised within the medical community to assist a person to exercise their preferences for the way they want to manage their end of life, including the role of palliative care;
- (2) review the current framework of legislation, proposed legislation and other relevant reports and materials in other Australian states and territories and overseas jurisdictions; and
- (3) consider what type of legislative change may be required, including an examination of any federal laws that may impact such legislation.

3. Palliative care

As per the inquiry’s terms of reference, the role of palliative care must form part of any examination of end-of-life issues.

Approximately 36,000 people die every year in Victoria, a figure which is expected to double in the next 25 years.¹ There will obviously be a corresponding increase in demand for the provision of palliative care, especially with an ageing population. This demand will be felt by government and private providers, both for institutional care (in hospitals, hospices, etc.) and for home-based care.

Exploring these challenges among others, the Victorian Auditor-General’s April 2015 report into palliative care found that:

palliative care in Victoria is delivered by skilled and dedicated staff who specialise in caring for people with a terminal illness. Indeed, Victoria has a strong palliative care sector and DHHS [the Department of Health & Human Services] has set a clear and ambitious agenda for what remains a relatively new area of health provision. However, a number of areas for further improvement remain.

Demand for home-based care is increasing and some metropolitan community palliative care services have struggled to meet this demand, resulting in waiting lists to access services. This can place additional stress on patients and carers, and can mean that some people who have chosen to die at home cannot spend their last days there. DHHS has committed to better forecasting demand for services and to work with palliative care services to better understand how to support carer needs and respond to unmet demand.

More also needs to be done to support carers and families. While there has been progress in some areas, improving respite provision and access to psychosocial support remain major priorities. Notably, 'support for carers' and 'engaging with the community' were two key priorities of DHHS's Strategic Directions that have not been met.

Going forward, it is imperative that DHHS sets clear expectations for service delivery across the state and provides sufficient and appropriate funding to health services and community organisations².

These are common sense findings which deserve support. It is imperative that they be followed by practical support to meet growing demand.

Recommendation 1

That Victorian palliative care services receive greater support to meet current and expected future demand.

Recommendation 2

In palliative care service provision, greater consideration should be given to home-based care and to the needs of carers and families.

4. Euthanasia and assisted suicide

4.1. Definitions

Though not necessarily taken by contemporary medical professionals, the Hippocratic Oath has informed medical ethics since the fifth century BC. In its original form, the oath includes the declaration: "I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan".³

The role of doctors and medical professionals is to save lives – not end them. Consequently, euthanasia and assisted suicide should not be considered a component of medical treatment.

Some confusion surrounding end-of-life issues is caused by a misunderstanding of definitions. The Australian Medical Association (AMA) provides the following explanations of euthanasia and assisted suicide:

Euthanasia is the act of deliberately ending the life of a patient for the purpose of ending intolerable pain and/or suffering.

*Physician assisted suicide is where the assistance of the medical practitioner is intentionally directed at enabling an individual to end his or her own life.*⁴

Euthanasia and assisted suicide are, therefore, the intentional ending of a life and should not be confused with medical end-of-life considerations. The AMA provides some points of clarification:

*the following forms of management at the end of life **do not** constitute euthanasia or physician assisted suicide:*

- *not initiating life-prolonging measures;*
- *not continuing life-prolonging measures;*
- *the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.*⁵

If laws were changed to allow euthanasia or assisted suicide, medical training would need to include courses on how to kill patients. Doctors would then be equipped to treat or kill their patients and patients could not be sure of the doctor's intention. This would forever destroy the bond of trust between doctor and patient.

4.2. Issues

The following list is far from exhaustive, but provides some examples as to why euthanasia and assisted suicide should not be considered by policymakers.

Pressure on vulnerable people

The introduction of laws for euthanasia and assisted suicide risks the wellbeing of society's most vulnerable members. These include the sick, elderly or disabled, who may feel themselves to be a burden on their loved one.

Experience in Oregon (US), which has "physician-assisted dying", shows that physical suffering is not a major issue for those requesting physician assisted suicide – but fear of being a burden is.

Of the 673 people who had died under the provisions of the Act as of 14 January 2013, only 23.5% listed "inadequate pain control or concern about it" as a consideration.⁶

Earlier annual reports noted: "Patients discussing concern about inadequate pain control with their physicians were not necessarily experiencing pain."⁷

By contrast some 38.6% of those who died after taking prescribed lethal medication cited concerns about being a "burden on family, friends/caregivers" as a reason for the request.⁸

Euthanasia and assisted suicide seem to be more about relieving other people of a "burden" than relieving unbearable or unrelievable suffering.

Mixed messages on suicide

Euthanasia and assisted suicide laws jeopardise the health of those struggling with depression and mental illness.

Sending a mixed message on suicide undermines the excellent work of mental health groups, both government and NGO, and sends the wrong message in a country with one of the highest youth suicide rates in the world.

According to the most recent figures, Australian suicide rates have reached a 10-year high and remain the leading cause of death for Australians aged between 15 and 44.⁹

In 2012, there were roughly 7 suicides daily – and Lifeline estimates that there are also around 200 suicide attempts, 250 people making suicide plans, and 1000 people thinking about suicide every day.¹⁰

Not only does consideration of euthanasia and assisted suicide undermine efforts for better mental health, there have been suggestions the debate is directly linked to a higher instance of youth suicide.

A 2007 article casts light on this connection:

Young Australian men in their prime commit suicide at the rate of nearly 400 per year. In 1997, when the Federal Parliament held a conscience vote on the contentious issue of the Northern Territory's euthanasia legislation, suicide peaked among Australia's 20-24 male population, reaching 40 per 100,000, which is nearly twice the current rate

As with copy-cat behaviour, merely drawing attention to the supposed right to take one's own life has only encouraged the practice.¹¹

Legalisation of euthanasia and assisted suicide creates a perception that some lives are worth more than others – and that there is a point at which life is no longer worth living. This message must be rejected.

Provision of palliative and psychiatric care

The practice of euthanasia has been found to have serious flaws in terms of patients seeking access to palliative care or psychiatric treatment.

The radical step of ending or taking a life would surely be considered only after all other avenues have been explored – yet the Belgian experience shows this is not the case. Disturbingly, a majority of euthanased patients were not previously visited by a palliative care team.

Barely a fraction of euthanased patients received a visit from a palliative care specialist or a psychiatric consultation, as a 2015 Belgian study documents:

When analysing the latest data provided by the Belgian Federal Euthanasia Commission (years 2012–2013), we see that only 40 percent (1,283 out of 3,239) of the euthanized patients had a visit by a palliative care team, barely 12 percent (396 out of 3,239) had a visit by a palliative care specialist, and just 9 percent (307 out of 3,239) were consulted by a psychiatrist (Commission Fédérale de Contrôle et d'Évaluation de l'Euthanasie 2014). Thus almost 40 percent of the patients who received euthanasia did not see a palliative care specialist nor interacted with a palliative care team.¹²

Given that pain and suffering are frequently-cited arguments in favour of euthanasia, it is concerning that experience shows euthanasia to be a first resort, rather than professional pain management. Likewise, considering the likelihood of depression and other mental health issues in such cases, it is alarming that appropriate care has been supplanted under a euthanasia regime.

It is entirely foreseeable that a similar situation could develop were euthanasia or assisted suicide to be countenanced in Victoria. This is especially the case with an ageing population creating greater demand for palliative care and other health services.

Effect on family and friends

There is also a question of the mental wellbeing of others involved in euthanasia and assisted suicide cases.

In Switzerland, a recent study found that about 20 per cent of family members or friends who witnessed an assisted suicide subsequently suffered from full (13 per cent) post-traumatic stress disorder or sub-threshold (6.5 per cent) post-traumatic stress disorder.¹³

In short, a significant number of a patient's family and friends are likely to suffer severe stress following the patient's premature death.

Child euthanasia

Warnings of euthanasia being a "slippery slope" have been validated by, among other consequences, the introduction of child euthanasia.

This abhorrent practice now occurs in several countries, either by de facto acceptance or with complete legality. Two examples are the Netherlands and Belgium.

Euthanasia is permitted in the Netherlands for patients aged 12 and over. Despite the supposed illegality of euthanasing children below that age, practice has long been different.

The Groningen Protocol, drafted in 2004 after extensive consultation between doctors, lawyers, parents and public prosecutors, provides criteria under which a child under aged 12 can be euthanased. While it does not provide a complete legal protection for doctors, it has resulted practically in a functioning regime for child euthanasia.

The Royal Dutch Medical Association has estimated that of newborn babies alone, some 650 are killed every year.¹⁴

Belgium, meanwhile, became the first country to officially legalise child euthanasia in 2014 – with no age limit. Trends indicate that Belgian child euthanasia numbers will likely increase.

Belgium introduced euthanasia laws in 2002. In 2012, there were 1432 recorded cases of euthanasia – an increase of 25 per cent from the previous year. From these figures, it is reasonable to envisage the Dutch child euthanasia numbers being replicated – or even exceeded – in Belgium.

Aside from questions of a child's capacity to make such a decision (namely, to end their own life), the Dutch and Belgian experience again demonstrates that acceptance of euthanasia or assisted suicide invariably affects the most vulnerable members of society.

4.3. Summary

As stated previously, concerns raised here regarding euthanasia and assisted suicide are far from exhaustive. These particular issues have been raised to give an idea of the deleterious effects caused by such laws.

Whenever lives are deliberately cut short, regardless of the legal framework, there are severe ramifications – not only for patients concerned, but also for family and friends, other vulnerable people, medical professionals, and whole societies.

Recommendation 3

Any proposal for euthanasia or assisted suicide should be soundly rejected by Victorian policymakers.

5. Conclusion

The term “end of life choices” encompasses a broad swathe of issues, of which this submission has addressed only a limited scope.

There is considerable pressure on the health system, particularly when it comes to services such as palliative care. With demand set to soar over coming decades, it is vital that greater resources be planned for and allocated – and a better diversification of services be included.

Good physical and mental health outcomes must be centred on a desire to uphold the dignity and worth of patients – and it is for this reason that policymakers should also resist any proposal to countenance euthanasia or assisted suicide. These are not forms of medical care and are fraught with unintended consequences.

6. Endnotes

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- ¹ Victorian Auditor-General’s Report into Palliative Care, April 2015, p. ix, http://www.parliament.vic.gov.au/file_uploads/20150415-Palliative-Care_tqn6dR9G.pdf
 - ² Victorian Auditor-General’s Report into Palliative Care, p. vii.
 - ³ *Greek Medicine – The Hippocratic Oath*, National Institutes of Health, https://www.nlm.nih.gov/hmd/greek/greek_oath.html
 - ⁴ Australian Medical Association, *Position Statement on the Role of the Medical Practitioner in End of Life Care 2007 (amended 2014)*, https://ama.com.au/sites/default/files/documents/ps_on_the_role_of_the_medical_practitioner_in_end_of_life_care_2007_amended_2014_0.pdf
 - ⁵ Australian Medical Association, *Position Statement on the Role of the Medical Practitioner in End of Life Care 2007 (amended 2014)*.
 - ⁶ Oregon Health Authority, *Oregon’s Death With Dignity Act -2012 Table 1, Characteristics and end-of-life care of 673 DWDA patients who died after ingesting a lethal dose of medication as of January 14, 2013, by year, Oregon, 1998-2012*, p 4.
 - ⁷ Oregon Health Authority, *Sixth Annual report on Oregon’s Death With Dignity Act*, 2004, p 24.
 - ⁸ Oregon Health Authority, *Oregon’s Death With Dignity Act -2012 Table 1, Characteristics and end-of-life care of 673 DWDA patients who died after ingesting a lethal dose of medication as of January 14, 2013, by year, Oregon, 1998-2012*, p 4.
 - ⁹ Lifeline, *Statistics on Suicide in Australia*, <https://www.lifeline.org.au/About-Lifeline/Media-Centre/Suicide-Statistics-in-Australia/Suicide-Statistics>
 - ¹⁰ Lifeline, *Statistics on Suicide in Australia*.

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- ¹¹ John Morrissey, "Male suicide rise linked to euthanasia debate", *News Weekly*, March 3, 2007, <http://newsweekly.com.au/article.php?id=3058>
- ¹² Tom Mortier, René Leiva, Raphael Cohen-Almagor & Willem Lemmens, *Between Palliative Care and Euthanasia*, *Journal of Bioethical Inquiry*, 22 April 2015.
- ¹³ B. Wagner et al., "Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide", *European Psychiatry*, 2012, 27: 5422-26.
- ¹⁴ Sue Reid, "The country where death is now just a lifestyle choice", *Daily Mail*, 2 January 2015, <http://www.dailymail.co.uk/news/article-2893778/As-debate-assisted-suicide-dispatch-Holland-thousands-choose-die-year.html>