Submission
to the

LEGISLATIVE COUNCIL
STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES
INQUIRY INTO END OF LIFE CHOICES

To:

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From:

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29th August 2015

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“End of Life Choices”

Death is a reality!

We will all die.

We may die very young or very old or at any point in between.

How we die will vary enormously. The causes of death vary hugely. The circumstances in which we die will ultimately be unique to each individual.

We may or may not have any opportunity to make so called “end of life choices”.

Others are often called upon to make decisions regarding treatment due to the patient being a minor or the patient being incapacitated.

This makes it enormously difficult to write about, let alone legislate, about “**end of life choices”**.

We all want to have a “good death”, even a happy death, if that is possible.

Making a “Good Death” Possible

As a society as have a responsibility to enable people to have the best death in their circumstances.

This explains why as a society we strive to reduce the road toll and work related accidents. Likewise we strive to remove other causes of death. A simple example is the campaign to stop smoking.

We want to remove or greatly reduce the incidence of accidental deaths.

This also explains campaigns to reduce the incidence of suicides.

Our community wants to see people live out their natural lifespan and eventually die a natural death.

The Role of the State

The first duty of good government is to protect human life, as Thomas Jefferson proclaimed.

The state has a duty to uphold and enhance the value of every human life, no matter whose life it is; no matter how disabled or frail the person may be; no matter how young or how old the person maybe.

I applaud the recent improvements in care for the disabled and the mentally impaired. These are positive advances

Given the positives of modern medicine, we can welcome acute medical care. Nevertheless in the best of patient care, there may come a point where continuing acute care is no longer appropriate.

I welcome the place of palliative care in medicine.

Palliative care is not a negative. Rather it has a long and noble history.

Today good palliative care must be available to every patient where it is appropriate.

Euthanasia or so called "Mercy Killing" is never the answer

Quite bluntly a "good death" will never come out of the end of a needle!

A "good death" will not come from a dose of a lethal pill!

Euthanasia is not the answer to human suffering much less to human misery.

Euthanasia is not the answer. Euthanasia is never the answer.

Euthanasia is the cheap and bitter offering of those who have nothing better to offer.

My own personal experience is that literally "in the last moments of life" there is very little talk of euthanasia. During my time working in patient

care at the Peter McCallum, I did not hear patients of relatives asking for euthanasia or mercy killing.

Yes, it is true that some unfortunate people want to end their lives. These people deserve to be listened to. Their call is almost without exception a cry from the heart, a cry of fear, a cry of loneliness. They deserve to be cared for in a warm accepting environment. As a society we need to go behind their words to listen to their hearts.

My experience is confirmed by the vast literature of those writing in the field of palliative care. It is supported by a sensitive article by Dr. Graeme Duke of the Box Hill Hospital published in the Sydney Morning Herald, 13 May 2015. Dr Duke wrote and it is worth quoting:

"According to popular opinion there is overwhelming community support for euthanasia. And yet when I listen to dying patients and families I discover this is simply not true. What they fear is loneliness, pain and indifference. What they prefer is quality to quantity, symptom-relief to suffering, time spent close to loved ones not machines, shared decision-making, and above all a doctor who will listen. This is not euthanasia. This is simply good medicine."

Euthanasia and so called "assisted suicide" are not palliative care! They are the direct opposites of palliative.

In the unthinkable circumstances that euthanasia and so called "assisted suicide" were to be legalised they would undermine palliative care as they are a cheap, quick fix solutions of a society which has lost its heart.

Advances Care Plans rather than Advanced Care Directives

To enhance patient care there be opportunities for patients to participate at the appropriate time in framing Advanced Care Plans. In the context of a patient's individuality and all the unforeseeable eventualities the collaborative framing of patient care be best formulated in terms of plans rather than directives.

My experience in patient care suggests that it is enormously difficult for a patient to personally frame directives because the circumstances which they may face will evolve. The patient is usually unable to formulate

meaningful and prescriptive “directives” for situations yet to be faced. Time and space does not allow be to elaborate to this point. Suffice it to say that those who are inclined to want to advocate such directives are often not sufficiently sensitive to the individual patients’ situations.

I do add a caution that even the plans I mention have to be very flexible.

I acknowledge the role of VCAT in the decision making process of those unable to make their own treatment plans due to age or infirmity. At all times VCAT must uphold the sanctity of every human life and the paramount good of the patient.

Conclusions

That the committee recommend in its report that there be a review of the funding of all aspects of palliative care to make it easily accessible for whom it is appropriate.

In particular that the committee call for greater funding for home based palliative care.

That the committee be mindful that various Australian parliaments have rejected sixteen moves in recent years to legalise euthanasia.

That there be no legislative changes which in any shape or form would open a path to euthanasia, mercy killing or assisted suicide.

That the committee make a **definite recommendation** against any form of euthanasia or assisted suicide.

To enhance patient care there be opportunities for patients to participate at the appropriate time in framing **Advanced Care Plans**. That these be called **plans** rather than directives.