VICTORIAN LEGISLATIVE COUNCIL

SUBMISSION TO INQUIRY INTO END OF LIFE CHOICES

LEGAL AND SOCIAL ISSUES COMMITTEE

Preamble: although the term euthanasia does not appear in the terms of reference, it is obvious from media reports of the Parliament and letters to the press that there is another move at foot to legalise so-called mercy killing in Victoria. Time and again such moves have stalled, principally because MPs were unconvinced that the voluntary aspect could be guaranteed, even if the principle of personal autonomy over the traditional objections towards suicide could be granted. I fear that such terms as “end of life choices” and “advance care directives” may serve as inducements towards irrevocable decisions to undergo voluntary euthanasia.

1. **How current medical practices and palliative care can assist a person [to] manage their end of life.**

Palliative/community care and more recent hospital management have always “managed” end of life, with increased longevity in recent decades making this issue more complex. In Australia we have excellent palliative care in some areas, but the spread is random. During the debate over the Northern Territory euthanasia laws it emerged that there existed almost no palliative care facilities in the Territory, and that a number of those who sought euthanasia were merely suffering from clinical depression. As a teacher in Melbourne’s outer-East area I was involved with the professional and voluntary members of the unit which helped the mother of one of my students in her last months, and was very impressed. As with this lady, palliative care for the elderly in their last days is a beautiful thing, and is anything but burdensome, although the outcome is inevitable. It would be a disgraceful state of affairs if so-called “end of life directives” were to replace palliative care as more cost-effective.

2. **How this issue is managed in Australian and other international jurisdictions.**

Hospitals today have developed documentation to record a patient’s choice in this matter, and I have been impressed with the detail and options. For example, one request by a competent patient or his/her trusted representative reads: “If I am acutely ill and it is reasonably certain that I will not recover, I want to die naturally in my familiar surroundings. I do not want my life prolonged by extraordinary or overly burdensome treatments. I wish to receive palliative care that includes treatments to keep me comfortable, pain relief, and be offered food and drink of my choice.”

An alternative request reads: “I would like all decisions about medical treatments to be made by doctors and those I have listed above. I request that they consider my wishes as outlined in this Advance Care Plan.”
A problem arises with such documents that once registered they become final and do not provide for revision as wishes change. Currently, hospitals which operate such plans do not regularly ask patients or their trusted representatives to review them. Unless definite requests like the following are included, the discretion is taken out of their hands: “I know that death need not be resisted by every possible means. I ask that I not be given any treatment that would not sustain me or give me comfort or relieve a condition that I have, or would be overly burdensome to me or others” and “I do not want my life to be ended or my death to be hastened by any act or omission that is intended to cause my death.” These requests can be even more specific, for example, whether breathing machines, feeding tubes or even CPR should be used. Where a patient or a competent trusted representative [Medical Enduring Power of Attorney] monitors these requests, the outcome may be optimal, but overseas experience shows that patients wholly at the mercy of the health system do not fare well.

We have the extreme case of the Low Countries, Netherlands and Belgium, where it is notorious that elderly patients who have expressed no wishes nor have competent representatives are arbitrarily given euthanasia, although this legal procedure is supposed to be voluntary. It is an open secret that hundreds of patients undergo euthanasia there each year, at the discretion of medical practitioners who have become used to “playing God” and exercising their own brand of pragmatism. Some years ago in Australia, the term “passive euthanasia” was coined to imply that pain-killing drugs which had the known but unintended consequence of hastening death were a form of euthanasia. This is thin edge of the wedge logic, when intention – however well-intended – is the issue.

3. **Potential changes to our legislative framework**.
   Making the documentation of end of life choices mandatory must be done in such a way that it is descriptive of wishes and not prescriptive.
   - There must be provision for review.
   - It must not be a step toward voluntary euthanasia, but rather strengthen our current Health Act, which has provision to refuse burdensome treatment.
   - It should not become a vehicle for denying resources to palliative care.
   - It should respect the dignity of human life, which is enhanced by our ability to care for the elderly and ill, and consider all aspects of their physical and psychological condition, including depression.

I respectfully ask the Committee to consider these points in response to this important Inquiry into such a complex issue.

John J Morrissey,