Submission to the Victorian Parliament Inquiry into “End of Life Choices”.

On behalf of the Group, **Christians Supporting Choice for Voluntary Euthanasia**

Author: Ian Wood, National Coordinator.

Summary of facts and argument in favour of a change in the Victorian law to give legal CHOICE in assisted dying/voluntary euthanasia for the terminally or hopelessly ill.

These are discussed in detail in the following pages.

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**We are - Christians who believe that, as a demonstration of love and compassion, those with a terminal or hopeless illness should have the option of a pain-free, peaceful and dignified death with legal voluntary euthanasia.**

*“Euthanasia is not a choice between life and death, but a choice between different ways of dying”.*

Jacques Pohier, a former Catholic Dominican Priest,

**After studying the changes in social values, medicine and the law, and in light of our comprehensive review of the issues and the arguments raised by hundreds of witnesses and thousands of comments, we have come to the conclusion that an additional option is needed in the continuum of end-of-life care: euthanasia, in the form of medical aid in dying.**

**Quebec National Assembly** all-party select committee Report, 2012.

This led to the passing of the Quebec “Act respecting end-of life care” Bill 52, by 94 votes to 22 on June 5, 2014.

**The Supreme Court of Canada**, February 2015, in a unanimous decision by 9 judges has stated “The prohibition on physician-assisted dying infringes the right to life, liberty and security of the person in a manner that is not in accordance with the principles of fundamental justice,” and gave the Canadian Parliament 12 months to introduce legislation to comply with the Supreme Court guidelines. **Victorians deserve the same fundamental justice!**
- The aims of Christians Supporting Choice for Voluntary Euthanasia

To make politicians aware that a majority of Christians in Australia support choice for voluntary euthanasia, holding it to be consistent with Jesus’ message of love and compassion.

To make the public aware through the media that there is strong public support amongst thinking Christians for our legal right to make end of life decisions.

To counter any mis-information put forward by religious opposition to every person’s right to a dignified and pain-free death.

- Christian support for assisted dying

The usual Newspoll question on voluntary euthanasia is, “If a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering, asks for a lethal dose, should a doctor be allowed to give a lethal dose or not?”

In 1962 47% said “yes” to a similar question and the percentage has steadily increased since then. This clearly indicates a major shift in public opinion over the 50 years.

In four polls through the 1990s the positive response was 76 to 78%.

In 2002 a Morgan poll showed national support at 73%. The responses among religious groups in South Australia were: Anglican 81%, Methodist 87%, Presbyterian 66%, Catholic 69%, Uniting Church 74%, Lutheran 74%, and Baptist 68%.

In 2007 the same question was asked in a Newspoll survey, with 80% of Australians saying “yes”. Of respondents who stated they had a religious affiliation 74% answered “yes”. (Ref 1)

In 2012, Newspoll found an overwhelming majority said yes (82.5%), a very small minority (12.7%) said no, with 3.8% don’t knows and 1.0% refused. Nearly nine out of ten Australian Anglicans, more than three out of four Catholics, and nearly all Australian atheists advocate assisted dying law reform. That is, the proportion of Anglicans in support is higher than among the general population! Religious hierarchy who comprise an organised opposition to law reform do not represent the views of the majority of their flocks. (Ref 2)

In the UK -

**Most religious people ignore their leaders and support a relaxation of the law**

An absolute majority of religious adherents – i.e. those who identify with a religious tradition – support assisted suicide: 64% of religious people support a change in the law on euthanasia, 21% think the law should be kept as it is, 14% don't know (sums to 99 due to rounding).

Anglicans are in favour of change by a margin of 57% (total in favour 72%) - which is greater even than the general population at 54% (total in favour 70%). Only those who say they have “no religion” show greater support – by a huge margin of 72% (total in favour 81%). (Ref 3)
Although not widely known, there has been support for assisted dying/voluntary euthanasia from Christian theologians since at least the 1930s.

The Right Rev. Dr W. Inge, former Dean of St Paul’s Cathedral, London, when founding the British Voluntary Euthanasia Legalisation Society in 1935, said, “It is not contrary to Christian principles.”

Among the founders of the American Euthanasia Society, in 1945, were prominent Christians such as the New York divines Henry Sloan Coffin, the President of Union Seminary, and Harry Emerson Fosdick, the minister of Baptist Riverside Church.

Rev. Trevor Bensch, a co-founder of Christians Supporting Choice for VE, former hospital chaplain and Minister of North Adelaide Baptist Church, South Australia, says: “My call for legal Voluntary Euthanasia is compassionate and thoroughly consistent with the teachings of Jesus.”

Highly respected Catholic theologian, Prof. Hans Kung, states: “As a Christian and a theologian I am convinced that the all-merciful God, who has given men and women freedom and responsibility for their lives, has also left to dying people the responsibility for making a conscientious decision about the manner and time of their deaths. This is a responsibility which neither the state or the church, neither a theologian or a doctor, can take away.” (Ref 4)

More recently, Lord Carey former Archbishop of Canterbury and head of the world wide Anglican church, speaking in support of the Falconer Assisted Dying Bill before the House of Lords, UK, said: it would not be "anti-Christian" to ensure that terminally ill patients avoid "unbearable" pain, and "One of the key themes of the gospels is love for our fellow human beings ... Today we face a terrible paradox. In strictly observing accepted teaching about the sanctity of life, the church could actually be sanctioning anguish and pain – the very opposite of the Christian message." (Ref 5)

Former Archbishop Desmond Tutu, one of the most revered religious leaders, also speaking in support of the Falconer Bill says: “I have been fortunate to spend my life working for dignity for the living. Now I wish to apply my mind to the issue of dignity for the dying. I revere the sanctity of life - but not at any cost.”. (Ref 6)

Canon Rosie Harper, vicar of Great Missenden and chaplain to the Bishop of Buckingham in UK, said she supports Lord Falconer’s Assisted Dying Bill which received its second reading in the House of Lords on July 18, 2014.

Canon Harper was one of three faith leaders backing the Bill during a debate on the issue hosted by Interfaith Leaders for Dignity in Dying in Westminster, London, July 17, 2014.
She described the assisted death of her uncle with Dignitas in Switzerland. "My uncle had a beautiful death, with his family around him - good music, good wine, and a pain-free end. The days that would have followed as he struggled through the end stage of a brain tumour would have been terrible. He had no choice about dying. He did have choice about the manner of his death. That's all this bill is offering."

"Nor do I believe that holding on to life at all costs is the uncontested goal of humanity. The crucifixion itself demonstrates that there are higher goals than the preservation of one's life. John 15.3: There is no greater love than to lay down one's life for one's friends."

She argued that a God who offered "freedom of will" would not insist on "extreme suffering" at the end of life when there was a different, better way. Addressing the arguments against, she continued: "First there is the contention that pain can always be controlled. We know that simply is not the case. Anyway - in what way is there value in a person being technically still alive if they are sedated to the point of oblivion?

Secondly, what this bill proposes is infinitely more honourable than what routinely happens now when a dying person is gradually and cruelly starved to death."

See Canon Harper's compassionate interview (approx 5 min) Youtube here http://www.christiantoday.com/article/senior.cofe.priest.why.i.am.pro.assisted.dying/38052.htm (Ref 7)

There is a significant indication of support for Physician-Assisted Death from the Society for Humanistic Judaism. For full details see http://www.shj.org/physician-assisted-death/

- The scaremongering and general lack of factual supporting data by religious opposition

An analysis of recent Parliamentary debate on assisted dying reveals opposing MPs who are known to have a religious background, rarely acknowledge their religion has influenced this opposition.

The trend for religious opposition is to use the alleged 'slippery slope' and the alleged coercion of the elderly and vulnerable, rather than the 'sanctity of life' and the 'Thou shalt not Kill' arguments in previous years. This is presumably because the 'Thou shalt not Kill', which should be translated as 'Thou shalt not murder', (that is kill with malice), is easily rebutted by citing the numerous examples of Biblical killing apparently approved or authorised by God. (Eg the story of Noah, genocide of the Midianites in Num. 31.7-9 & 17-18, etc)

Prof. Hans Kung commenting on the Evangelium Vitae on abortion and euthanasia by Pope Paul II, states: "The remarkable thing is the same Pope, who still allows the imposition of the death penalty for 'cases of absolute necessity, when it would not be possible to otherwise defend society' thinks that in questions of help in dying he must advance a thoroughly rigorous view with reference to the sanctity of life (which now once again is made absolute)." Kung also questions how Pope Paul II would allow the "passive help" of turning off a ventilator, but not the increasing of a dose of medication with fatal consequences, pointing out the distinction is theoretically contradictory – can any action be passive? (Ref 8)
NSW MLC Dr JOHN KAYE said during debate on Rights of the Terminally Ill Bill: 2013
“Some objections are emerging from a purely dogmatic narrow interpretation of the right to life. Many of those arguments have relied on misleading and downright mendacious tactics and none more so than Cardinal George Pell in his letter of 8 May on behalf of the Catholic bishops of New South Wales. The letter contains four substantial lies. It is a deliberate attempt by the cardinal to mislead the people of New South Wales and, in particular, to mislead his flock. Cardinal Pell states: Despite talk of "dignified death", dignity is not served by telling the old and dying, through our laws, that they would be better off dead and we would be better off if they were dead. It is simply a lie to say that this bill tells anyone they would be better off dead,” said Kaye. (Ref 9)

Cardinal Pell’s letter failed to mention that a voluntary request from the terminally ill person was required, used emotive language such as killing and incorrectly stated that overseas experience shows that others will be involuntarily euthanased once a country goes down the euthanasia path.

The Anglican Synod of Sydney in 2010 expressed opposition to voluntary euthanasia along predictable lines. They stated palliative care is sufficient, except for a tiny minority. (but have no empathy for that minority) They alleged legislation will lead to patient mistrust, creeping expansion, reduced funding for PC and that most supporters for euthanasia are young and healthy, none of which is supported by data from overseas

The Synod failed to note the legislation they were referring to was only for the terminally ill. (Ref 10)

During debate on the Tasmanian Giddings/McKim Assisted Dying Bill 2013 (Ref 11) Ms Jacquie Petrusma MP made a number of questionable statements. For example, note the way this sentence is worded. The Oregon 2013 report indicates that being a ‘burden on family, friends and care givers’ is the major reason for requesting assisted suicide for 38.6 per cent of those who had died versus 23.5 per cent for ‘inadequate pain control or concern about it.’ This is misleading, as she does NOT quote anywhere the actual 3 major end-of-life concerns: loss of autonomy (93.0%), decreasing ability to participate in activities that made life enjoyable (88.7%), and loss of dignity (73.2%) (Year 16 Oregon Report) Ms Petrusma did not acknowledge she is a conservative Christian.

Ms Petrusma also said, There was a complication rate of 4.5 per cent for regurgitation between 1998 and 2009. This is misleading! The regurgitation rate has markedly improved in the last 4 years. She quotes and selects time periods to suit her argument! In 2010 1 person regurgitated out of 65, in 2011 = 1 out of 71. However in the last three years there have been no regurgitations She also failed to mention that the Oregon Report stated that the two latter patients had been vomiting prior to ingestion!

- Reputable polling in support vs the manipulation of on-line polling

The importance of reputable scientific Polling was outlined in Point 2, however it appears on-line polls have been manipulated by those opposing.
For example, I have no reason to doubt the authenticity of this email from the HOPE no euthanasia group. Wed, Nov 24, 2010 Subject: Vote tonight on euthanasia

Dear Friends, Thank you so much to everyone who took the time to get involved in the two online polls yesterday – both won hands down! When I first sent out the message about the advertiser [the Adelaide Advertiser newspaper] poll the NO vote was at an abysmal 16%. Just a moment ago the No vote was at nearly 74%. Alex Schadenberg from Canada thanks you all for your support with his poll and, likewise, we need to thank our Canadian friends for their votes.

This really proves the power of networking. I encourage you all to ask all your friends to register on the HOPE website so we can keep building the opposition and the network. This is so important for the long haul. (Ref 12)

Another example of poll rigging –
The BMJ invited its readers to respond to the editorial by voting for or against neutrality. Astonishingly, over 80 per cent of those who voted were against neutrality – the opposite of what had been found in the scientific poll. This surprising result prompted an analysis of voting patterns. In a two-day period, there was a huge surge in votes. During this time, there were many anomalies, the most striking being one individual, apparently located in Iceland, who voted against neutrality 168 times. One could not have clearer evidence of how the debate against assisted dying is being hijacked. This is a rerun of what happened in 2006 when Lord Joffe’s Bill for legalising assisted dying was being debated in the House of Lords. The Euthanasia Prevention Coalition – an international body based in Canada – flooded two polls of British public opinion, one run by Bath University and one by the Evening Standard, with “No” votes from Canada and USA. (Ref 13)

- The reality when good palliative care is not effective in relieving suffering

Pain and existential suffering
Physical pain should not be the ultimate criteria for a rational request for an assisted death. Perhaps more important is the suffering endured when the body becomes “unbound”.
“ ‘unbounded’ includes symptoms such as incontinence of urine and faeces, uncontrolled vomiting (including blood and faecal material), fungating tumors, gross oedema causing the skin to burst, rupturing tumors”, states Julia Lawton. (Ref 14)

There is increasing evidence that, for many terminally ill patients, having their request approved for an assisted death is of immense psychological and palliative value to them. Dr Erika Preisig, of LifeCircle, an assisted dying organisation in Switzerland, says, “Again and again it (my experience) shows that members find new energies to go on living when they know they have the green light for an assisted voluntary death.” It provides peace of mind, and in many cases they live longer than a person who does not request assistance! (Ref 15)

Dr Rodney Syme, Victorian Doctor, states: For over 25 years I have been counselling people about their end of life concerns. Those conversations are prolonged and open ended. At all times, I endeavour to help people to go as far with their lives as possible. From that experience I have learnt one invaluable lesson – my first self-
evident truth – that giving people control over the end of their lives is one of the most valuable palliative tools we have at our disposal. (Ref http://www.dwdv.org.au/documents/item/56)

The Truly Vulnerable Those opposing assisted dying often allege concerns about ‘vulnerable’ groups, the elderly and those with disabilities. Yet they do not talk about another major group others consider truly vulnerable. Those who are actually suffering with a terminal or incurable illness, who are vulnerable to futile treatments being needlessly inflicted on them by doctors who refuse to face the FACT that the patient is going to die and in many cases the side effects of this futile treatment are worse than the illness itself.

“Up to 70% of people now die in acute hospitals, surrounded by well meaning strangers, inflicting all that medicine has to offer; often resulting in a painful, distressing and degrading end to their life.” and “Clinicians themselves are often complicit in refusing to face the inevitability of dying and death.”, states Dr Ken Hillman, Professor of intensive care at the University of NSW in Sydney. (Ref 16)

Dr Charlie Corke, Palliative Care, Geelong Hospital, VIC says, “He ‘inflicts’ treatments he would not want done on himself.”
He had a problem stopping doctors inflicting treatment on his dying father. The doctors were acting against the wishes of the father and Dr Corke.
He states that the greatest act of LOVE is permission to “let go”. (Ref 17)

“If I was dying with pain, delirium and vomiting of faecal material, for example due to an inoperable blocked bowel, I would prefer the legal choice of a death within minutes, thanks.” Ian Wood.

Terminal sedation – slow euthanasia?
All members of my group would agree that the terminally ill need to be treated with compassion and care, supported by family, friends and the community, and treated as precious members of the human family.

We also believe that palliative care provides an essential service for the dying. However we know that the facts show even the best PC does not provide ‘remedial solutions’ to 2 to 5% of those dying. Symptoms such as uncontrollable vomiting of blood and faecal material due to an inoperable blocked bowel, is an example where pain relief is not effective.

The last resort in palliative care, when all else fails, is to put the person into a medically induced coma, known as terminal sedation, where they gradually starve or dehydrate to death, a circumstance that family and the nursing and medical staff can find extremely distressing to watch.

Terminal sedation is accepted by the medical profession and the Catholic Church as an appropriate and religiously ethical last resort, as the stated intention is ‘to relieve suffering’. No reporting is involved, and the patient need not even be asked.

Yet if the dying patient requested, “Rather than starve me to death in a coma, with the trauma of having my family watch this slow death, please give me the next few days medication in a single dose”, this would be illegal.

As Christians we ask why it is morally acceptable that the slow death procedure should be legal but not the other alternative?
To quote Dr Rodney Syme: It (terminal sedation) remains the 'Achilles heel' of palliative care because it is used in exactly those circumstances where other doctors might provide assisted dying if they were asked. And this very process is only associated with patient consent in up to 50% of deaths, with no opportunity to say goodbye.

Far from acknowledging terminal sedation, palliative care has been assiduously arguing, that neither if nor morphine alone, if used in a proper palliative way, ever hastens death. Terminal sedation is justified for the treatment of 'refractory' or 'intractable' symptoms, as determined by the clinician, not the patient. Maltoni and colleagues stated that "Despite the huge progress made in palliative medicine in terms of symptom control, many are intractable symptoms, either because the treatment is ineffective or because the treatment itself is intolerable". (ref http://www.dwdv.org.au/documents/item/56)

I have quoted in more depth on pages 10 and 11 of this submission the conclusions of the Quebec Parliamentary Inquiry but the following point is particularly relevant here: Regarding the issues surrounding end-of-life practices, there seems to be a very fine line between continuous palliative sedation, refusal or cessation of treatment, and medical aid in dying. In all three cases, the end result is death, ……

“A review of the literature has found great variability in the prevalence of palliative sedation, ranging from 2% to 52% among terminally ill patients. The study conducted by Ventafridda et al found that more than 50% of cancer patients dying at home die with physical suffering that is only controllable by means of sedation. Between 10% and 50% of patients in programs devoted to palliative care still report significant pain 1 week prior to death. The most common symptoms experienced by these patients were dyspnea (uncomfortable shortness of breath), pain, delirium, and vomiting. Most symptoms are reported to be physical in nature. In a retrospective analysis by Kohara et al, 54% of patients were found to have more than one uncontrollable symptom.” (Ref 18)

**The current law on assisted suicide is irrational**

Dr Rodney Syme, a Victorian doctor, has publicly admitted supplying fatal medication to Steve Guest and more recently to Ray Godbold, both with terminal cancer. Strictly speaking this is against the law, but it seems the Prosecutor is not charging Dr Syme with any offence and rationally most Australians would agree that Dr Syme is acting with due care in the best interests of the dying patient and is not committing any offence.

It therefore seems completely logical to CHANGE the law. Victoria can still maintain that assisting a suicide is, in general, against the law, but provide the legal exception for medical assistance, subject to adherence to a list of proscribed criteria. We note the action of Dr Syme in supplying fatal medication to Steve Guest was supported in an unpublished letter to an editor signed by 98 other doctors. (Ref http://www.rationalist.com.au/dr-rodney-syme-champion-of-human-rights/)

**Alzheimer’s – a difficult situation and the need for compassionate choice**

Alzheimer’s would be without doubt the illness most feared by the members of Christians Supporting Choice for VE!
We note that Belgian legislation does permit a person with Alzheimer’s to use an assisted death, during the window between a confirmed diagnosis and the lack of ability to make a rational conscious request.

The assisted death of Hugo Claus, an Belgian author who had Alzheimer’s, as described by his wife, Veela Claus-de Wit, in the Terry Pratchett documentary, “Choosing to Die” 2011.

“After we had shared champagne and he had a cigarette, he said I think I want to lie down. I lie down next to him and I hold him and I sing a song to him and he started singing with me – he died singing. It was so intense and warm – how can people be against it?”

I could do without the cigarette, but would love to die singing! (My personal comment)

Compare this death of Hugo Claus, with the more typical situation described below.

A visit to any high dependency nursing home in Australia will show patients suffering from dementia, Alzheimer’s, severe Parkinson’s disease, massive stokes and other demeaning and crippling conditions.

Bedridden, needing to be fed and changed like babies, incontinent lying in napkins soiled with urine and faeces despite the best efforts of dedicated nursing staff, unaware of their surroundings and close relatives unrecognised, would they want this if they could choose?

In lucid moments rather do they plead "God take me, please let me die "  (Ref 19)

- Chantal Sebire and why the author of this submission personally supports choice in assisted dying for the terminally or hopelessly ill

Ms Sebire told AFP that she suffered from a very rare disease called esthesioneuroblastoma, which attacks the nasal cavity. It had left her blind and had robbed her of almost all other senses, leaving her in terrible pain.

"In 2000, I lost my sense of smell and taste, and then the tumour evolved and ate into my jaws, before attacking the eye socket. I lost my sight in October last year," she said. The disease caused “atrocious bouts of pain that can last up to four hours at a time”.

Pleading to be allowed to die serenely, the mother of three said that only 200 cases of the disease had been reported globally in the last 20 years. (Ref 20)

This article was a deciding factor in Christians Supporting Choice for VE co-founder, Ian Wood’s decision to take a public stand on DWD. He says, “Had Chantal lived in Switzerland, Netherlands, Belgium, Luxembourg or Oregon, Washington State, Montana, and now Vermont, USA, she would not have had to suffer and asks are we so different in France or Australia?”
- The conclusions of the Quebec Parliamentary Inquiry 2012

These conclusions for Quebec citizens are equally valid for all Australians.

Some conclusions (quotes) from the Quebec National Assembly all-party select committee that held hearings and deliberated for two years. (178 page Report) 2012

After studying the changes in social values, medicine and the law, and in light of our comprehensive review of the issues and the arguments raised by hundreds of witnesses and thousands of comments, we have come to the conclusion that an additional option is needed in the continuum of end-of-life care: euthanasia, in the form of medical aid in dying.

Furthermore, we find that a growing number of physicians believe it is their responsibility to comply with a request for help to die. For them, when the end of life becomes intolerable, medicine must intervene out of compassion, in a spirit of human solidarity and respect for the patient’s freedom of choice.

Many believe that if medicine can act when a person is born, it should also do its part to help with death when justified by the circumstances. A large majority of physicians seems to share this opinion, as evidenced by the results of member polls conducted by the Fédération des médecins omnipraticiens du Québec (FMOQ) and the Fédération des médecins spécialistes du Québec (FMSQ) towards the end of 2009. According to the FMOQ poll, 75% of physicians would like to see “new regulatory and legislative guidelines allowing recourse to euthanasia”, while the FMSQ poll concluded that 75% of physicians are in favour of “legalizing euthanasia within a clearly defined legislative framework”.

We are therefore seeing a change in the mentality of the medical profession in Québec. The Collège des médecins itself has suggested that euthanasia could today be viewed as consistent with the spirit of the Code of Ethics of Physicians and constitute, under exceptional circumstances, the final step in the appropriate end-of-life continuum of care.

Some suffering cannot be effectively relieved, and individuals who want to put an end to what they consider senseless, intolerable suffering face a roadblock that goes against Québec society’s values of compassion and solidarity.

Medical aid in dying would therefore become an option for this small number of patients in exceptional situations, provided the act is strictly controlled and limited, and the patient himself makes a free and informed request to this effect.

The medical aid in dying option takes into account the issues raised by the experts and witnesses at the general consultation as well as by the thousands of citizens who participated in the online consultation. It provides a solution to the issues of suffering and compassion in many end of life situations. It also addresses the fear of abuse. Finally, it meets a need that was stated with emotion and maturity, and is a safe course of action, provided the necessary precautions are diligently taken.

Despite its undeniable importance, palliative care is not always the right answer for all end of life persons, particularly those with uncontrollable pain.
The medical aid in dying option would thus offer an alternative to this small number of people. It would not be in keeping with our social values to refuse such assistance just because palliative care is not uniformly accessible across the province.

Based on the experiences abroad, we are convinced that medical aid in dying would in no way compromise the future development of palliative care.

Regarding the issues surrounding end-of-life practices, there seems to be a very fine line between continuous palliative sedation, refusal or cessation of treatment, and medical aid in dying. In all three cases, the end result is death, ……

In this regard, despite the reticence of an age-old medical culture committed to maintaining life at all costs, the medical aid in dying option should, like continuous palliative sedation and refusal or cessation of treatment, be one of the choices available at the end of life.

Medical aid in dying does not endanger the common good; rather, it forms an integral part of it by offering one more option for those nearing the end of their lives, without posing a threat to society’s most vulnerable members.

The Report comment on the ‘euthanased without consent’ in Belgium. It is false to say that many patients are euthanized without their consent. These patients receive continuous palliative sedation when they are unable to express consent, when they are dying, and when the doctor and family believe that it is the best way to ease their suffering. (Ref 21)

The conclusions of the Australia 21 Report The Right to choose an assisted death: Time for legislation? clearly demonstrates the need for legislative change from the Australian viewpoint. (Ref 22)

- Conclusion

The Northern Territory Rights of the Terminally Ill Bill was passed in 1996 then overturned by the Howard Federal Government. Since that time conclusive evidence from a number of jurisdictions has demonstrated having the legal choice of an assisted death can and does operate successfully.

My group, Christians Supporting Choice for VE believe that, as a demonstration of love and compassion, those with a terminal or hopeless illness should have the option to choose a pain-free, peaceful and dignified death with legal voluntary euthanasia or assisted dying.

The Victorian Parliament Inquiry presents a wonderful opportunity to give compassionate CHOICE in dying for the terminally and hopelessly ill, in legislation with extremely rigorous safeguards.

Please consider the facts and ignore the scaremongering.

I would welcome an invitation to appear before the Inquiry.

Ian Wood
National Coordinator: Christians Supporting Choice for Voluntary Euthanasia
Website: www.Christiansforve.org.au
ADDENDUM - a request for an assisted death is generally a rational choice.

The following article is recent and relevant to the euthanasia debate. I submit that the entire article should form part of the INQUIRY evidence.

Pathologizing Suffering and the Pursuit of a Peaceful Death

doi:10.1017/S0963180114000085

BEN A. RICH (Professor and Chair, Bioethics University of California–Davis School of Medicine Sacramento, California)

Abstract: The specialty of psychiatry has a long-standing, virtually monolithic view that a desire to die, even a desire for a hastened death among the terminally ill, is a manifestation of mental illness. Recently, psychiatry has made significant inroads into hospice and palliative care, and in doing so brings with it the conviction that dying patients who seek to end their suffering by asserting control over the time and manner of their inevitable death should be provided with psychotherapeutic measures rather than having their expressed wishes respected as though their desire for an earlier death were the rational choice of someone with decisional capacity. This article reviews and critiques this approach from the perspective of recent clinical data indicating that patients who secure and utilize a lethal prescription are generally exercising an autonomous choice unencumbered by clinical depression or other forms of incapacitating mental illness. (My emphasis)

Conclusion of this article

In reviewing the ground that we have covered, some perspective is important. If the experience with the ODWDA teaches us anything, it is that a very small subset of terminally ill patients seek a lethal prescription, and an even smaller group actually utilize that option. Consequently, the impact of permitting this option has not had a profound impact on how people confront terminal illness or how most patients are cared for by physicians. Like abortion, legalizing lethal prescriptions for the terminally ill has generated a level and intensity of bioethical controversy that is markedly disproportionate to the number of persons actually impacted by it. Nevertheless, confronting these issues compels us to elucidate the core values in medicine and the limits, if any, on the well-recognized duty to relieve suffering.

The increasing involvement of psychiatry in palliative care has, up to this point, been a mixed blessing, for reasons I have sought to illuminate. To the extent that suffering associated with terminal illness is viewed as something that the patient must work through with a therapist, it is removed from the domain of natural human experience. By the same token, to the extent that we think of suffering as an often inescapable dimension of life’s final chapter, physicians are absolved of their professional responsibility to alleviate it. Either way, the suffering patient is caught in the middle.

One could understandably conclude that those who seek to expand the range of options for addressing terminal suffering, up to and including legalization of lethal prescriptions and recognition of a professional obligation to offer sedation to unconsciousness as a legitimate palliative option, are (properly in my view) focused on the plight of the patient, whereas those who would pathologize suffering and strictly curtail the patient’s ability to determine that she has had enough of suffering and wishes to pursue a peaceful death are obsessively and inappropriately focused on the plight of the physician. (My emphasis)
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Ref 4: A Dignified Death, Hans Kung.

Ref 5: http://www.theguardian.com/society/2014/jul/12/archbishop-canterbury-carey-support-assisted-dying-proposal


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Ref 8: A Dignified Death, Hans Kung.

Ref 9: NSW Hansard, Legislative Council, 22 May 2013


Ref 12: Email on file

Ref 13: http://rationalist.org.uk/articles/2848/the-case-for-assisted-dying

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Ref 15: http://www.lifecircle.ch/

Ref 16: Ken Hillman, Dr Ken Hillman is a professor of intensive care at the University of NSW in Sydney, Vital Signs 2009.

Ref 17: Book Saving Life …or prolonging death, Dr Charlie Corke


Ref 19: letter on file from a doctor


Inquiry into End of Life Choices

I wish to make an additional submission regarding a number of points in the Victorian Palliative Care (VPC) Submission to the Victorian “End of Life Choices” Inquiry.

Terminology. The VPC submission refers to “euthanasia”. In the context of the Inquiry, it should be referred to as “voluntary euthanasia”, i.e. at the request of the person concerned. I also submit that it is preferable to refer to “assisted dying” or medical assistance in dying” rather than assisted suicide – this leaves the connotations of suicide to people who generally would be considered to have a life ahead of them.

Page 3 of VPC submission “Our submission considers the options of euthanasia and assisted suicide with reference to available information and evidence of these practices, particularly in the Netherlands, Belgium and Oregon. In all three jurisdictions, the evidence indicates an annual increase in the use of these options of 15% or more, with signs of more rapid increases as the scope of these practices broadens.”

According to the Oregon 2014 Report, assisted deaths in 1998 (the first year) were 16, and in 2014 were 105. A 15% annual increase from the initial 16, obviously a very low starting base, would be 150, not 105. Would VPC please provide details of this calculation for Oregon? On page 22 the submission quotes a 14 % increase over the last 5 years.

- Fact. The number of assisted deaths is by no means a straight upward line, in fact in 4 of the years, 2001, 2004, 2009 and 2013, the number of assisted deaths dropped from the previous year.
- The total number of assisted deaths remains extremely low at 31.0 DWDA deaths per 10,000 total deaths, (Ref: Oregon Report 2014), an increase of only 5% a year since 1998.
- The criteria for accessing assisted dying and the scope of assisted dying practice in Oregon has NOT broadened since it began back in 1997.

The VPC submission ignores the fact that over 93% of those seeking an assisted death in Oregon are also enrolled in hospice care. These people obviously want an alternative to PC.

Page 14. “Achieving the effective management of pain and other symptoms is a high priority in the care of people with a life limiting illness and people who are dying.” According to Oregon Reports relief of pain is lower (24.7%) on the list of patient reasons for requesting assistance to die than “Losing autonomy” (91.5%) inability to enjoy aspects of life (88.7%), etc, in 2014. Relief of pain is not high on the patient’s own priorities. This Oregon table is actually included on page 19 of the VPC submission.
On Page 16, the VPC submission has the following table

<table>
<thead>
<tr>
<th></th>
<th>Palliative sedation</th>
<th>Euthanasia &amp; Assisted Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy intention</td>
<td>To relieve suffering through palliative means without intent to cause death</td>
<td>To end suffering by causing death</td>
</tr>
<tr>
<td>Method</td>
<td>The selection and carefully titrated use of drugs with palliative indications to</td>
<td>The selection and use of drugs in appropriate doses to cause death quickly and effectively.</td>
</tr>
<tr>
<td></td>
<td>relieve suffering at the lowest dose necessary.</td>
<td></td>
</tr>
<tr>
<td>Outcome</td>
<td>Management of refractory symptoms to reduce suffering</td>
<td>Death of the patient.</td>
</tr>
</tbody>
</table>

This table suggests that death is NOT a result of palliative sedation! This cannot be true and defies logic!! Palliative sedation is also known as ‘terminal sedation’ and for good reason.

Reference - the Quebec Parliament Report 2012 “Regarding the issues surrounding end-of-life practices, there seems to be a very fine line between continuous palliative sedation, refusal or cessation of treatment, and medical aid in dying. In all three cases, the end result is death…..

The table correctly states that an assisted death will cause death quickly, but omits to state that the palliative sedation death is slower and prolonged. This is why legal CHOICE for EITHER palliative care OR a medically assisted death should be an option for the terminally or hopelessly ill.

Page 26 repeats the old chestnut of Netherlands people carrying “Do not Euthanase” cards. This was rebutted in a letter to the BMJ by a Dutch euthanasia specialist http://www.bmj.com/content/342/bmj.d3187.short

Page 28 The submission cites, from a magazine article, Tom Mortier, but omits to say that Mr Mortier had been estranged from his mother for many years, as I understand the situation.

To quote Prof. Jan Bernheim from Belgium - Tom Mortier’s crusade against the alleged illegitimate euthanasia of his mother, who suffered from lifelong refractory depression. Mortier, who lives half an hour away from his mother, had long been estranged from her and did not reply to her message that a procedure to die by euthanasia was underway. In contrast, his sister, who works in Africa as a human-rights lawyer, expressed dismay and sorrow, but said she could not but respect her mother’s resolve. Eventually, the procedure lasted eight months, involving several psychiatrists and scores of consultations before the request was granted. A priest was intensely involved. There are other details that cannot be revealed due to medical confidentiality. You need not know details or be an expert to diagnose Tom Mortier’s predicament: pathological bereavement. This is a well-known clinical entity that mainly occurs in people who had a troubled and guilt-ridden relationship with the deceased. This is sad, but should not obscure the larger picture: a large-scale Dutch study found less pathological bereavement among the next-of-kin of people who died by euthanasia than “naturally”. Mortier deserves and should get empathy, compassion and therapy. Reference: document on file.

Page 30 Experience in Switzerland shows that a trained person, not a doctor, is suitable to be present at the time of self administration, so the VPC submission makes an interesting suggestion on this aspect. However it does ignore the fact that a number (no actual data available) of Australian doctors have indicated willingness to assist if they were legally able to do so.

While the VPC submission clearly opposes legalisation of assisted dying, their suggestion is that if it did become legal then – “A mobile euthanasia unit with trained staff to perform this function and relevant equipment could be established as part of an independent service operated by the Victorian Government that has full responsibility for implementing the legal provisions.” This concept would be worthy of evaluation and consideration by the Inquiry.
In fact The Netherlands do have mobile units available to give a second medical opinion and other support to doctors who have received a request for an assisted death from their patient. This did lead to complaints about 'broadening' by those opposing choice in assisted dying. Unfortunately I can envisage such a mobile unit being picketed by some of the more vocal opponents of VE in Australia as they do now with some abortion clinics.

I am willing to appear before the Inquiry if requested.

Sincerely

Ian Wood