27 July 2015

Hon Edward O’Donohue MLC
Chair
Standing Committee on Legal and Social Issues
Legislative Council
Parliament of Victoria

Re: Inquiry into End of Life choices 2015

The members of the Christian Medical and Dental Fellowship of Australia (CMDFA) welcome this opportunity to make a submission to this inquiry regarding End of Life choices in Victoria. As medical practitioners, we have a unique perspective regarding current end of life care practices and an interest in any legislative changes proposed. We attach our organisation’s official position statement paper which discusses our opposition to euthanasia and physician assisted suicide (PAS). We would also like to express our views about this inquiry in particular as we address the terms of reference.

Terms of Reference

That pursuant to Sessional Order 6 this House requires 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 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.

Firstly, we would like to comment on community expectations regarding end of life care. As doctors we are aware that there is poor understanding in the general public regarding what is currently available at the end of life with regard to medical care, and this ignorance promotes fear for many people. More well-informed community discussion is required to familiarise the general public regarding what choices are currently available at the end of life. It is possible to have control over end of life care under current legislation. We believe that medical practitioners have the responsibility to provide excellent end of life care, but that this does not always occur due to many problems, including inadequate resources. It is not the role of medical practitioners to provide every service demanded by the general public. Our role is to use our expertise to provide care which we think is best for the patient before us, within the boundaries of informed consent from the patient.

We would like to bring to your attention a number of options currently available to support patient choices for management of end of life care.
Advance care planning. Currently there are many initiatives in Australia promoting advanced care planning, which allows patients the opportunity to express any preferences for future medical care in case at some time they are unable to communicate, for example see http://advancecareplanning.org.au/resources/victoria

The right to refuse treatment. Many patients are not aware that mentally competent adults have the right to refuse treatment at any time (apart from some psychiatric situations) under the current law. Knowledge of this option would relieve many citizens who fear life-prolonging measures, especially burdensome or futile treatment, for terminal illness.

Palliative care. Palliative care philosophy promotes patient-centred care and patient preferences are paramount when care plans are made. Knowledge of palliative care networks are available to all Victorians through the Palliative Care Australia (http://palliativecare.org.au) and Palliative Care Victoria (http://www.pallcarevic.asn.au) websites and further palliative care information is also available through the federally funded Caresearch website (http://www.caresearch.com.au/Caresearch/Default.aspx). However, we acknowledge that further expansion of palliative care services is required before all Victorians will have access to palliative care when it is needed. However, such inadequacy of service provision (often associated with inadequate funding) does not indicate a need for legislative change. Palliative Care Australia has developed a strategy to improve the current situation. (1)

Palliative care allows for the provision of adequate relief of pain and other symptoms. Contrary to popular belief, medications such as morphine and sedatives do not shorten life when given in therapeutic doses. In fact, there is evidence that patients on high doses of analgesia survive longer. (2) Furthermore, there is Australian research which demonstrates that patients who believed they wanted to end their lives changed their mind once palliative care was commenced. (3) We believe that patients who receive good palliative care at the end of life are able to express and receive care according to their own preferences and, with adequate funding, are usually able to die in the setting of their own choice. Palliative Care Services need to be funded to adequate levels to make this service available for all Victorians.

(2) Review the current framework of legislation, proposed legislation and other relevant reports and materials in other Australian states and territories and overseas jurisdictions;

Evidence from jurisdictions where euthanasia is legal shows that the provisions for the law to be enacted are widened beyond those with a short prognosis to include other categories of patients who are not terminally ill. For example in the Netherlands, euthanasia was initially intended for those terminally ill patients who were mentally competent and experiencing intolerable suffering at the end of life. By the time the law had passed, the courts had already legitimized the death of patients who were not terminally ill. Then they allowed it for people whose suffering was not physical. (4) The first example was a recently bereaved but otherwise healthy woman. Mentally incompetent patients started to receive euthanasia. 12-16 year olds can and do die with parental approval. The Dutch are currently debating the need to allow people over 70 years of age to be killed when they are ‘tired of life’. (5)
Finally, a Dutch hospital published their guidelines on how to kill disabled newborn babies. (6) Similar problems occur in other jurisdictions, such as Belgium, where euthanasia for children of any age is legal, (7) and the United States, where physician assisted suicide has been legalised. (8, 9)

This is what they mean when they talk about a slippery slope. It is not scare-mongering. It is happening. Furthermore, it is well documented that euthanasia and PAS laws have been abused in those jurisdictions where they are active. The rate of euthanasia is continuing to increase each year in the Netherlands (10) and Belgium (11) and the most rigorous review of the Dutch legislation to date shows that 20% of cases are not reported and the problem of euthanasia without the knowledge and consent of the patient continues to exist. (12) We would be naïve to think we can develop legislation with adequate safeguards when other countries have not been able to.

In the Dutch legislation, there is no definition of suffering, even though this is the justification for the practice of euthanasia. This is an area of increasing medical research, and we now recognize that suffering often involves an existential component. (13) Most people are scared of dying, which is understandable, and seek to find control any way they can, such as by controlling its timing. Through medical research some useful (and not widely used) therapies have already been developed which can treat this fear and allow more peaceful death. (14) A more appropriate response to those suffering would be to propagate such treatments and continue research. It is not well known why patients request euthanasia, although what evidence we do have suggests that physical problems such as pain are uncommon. Psychosocial concerns are much more likely to precipitate a desire to die. (15) Requests to die are also associated with depression, a potentially curable disease which impairs judgment in decision-making. (16) Requests for euthanasia are sometimes cries for help which are misinterpreted. (17) And requests for euthanasia to be legalized are much more common in healthy people than those at the end of life, who often want more time, not less. (18)

Throughout history medical practice has continued to improve because we continue to seek cures for our patients in their distress. Expressions of distress in patients need to be met with care and support, not legislation for euthanasia.

(3) Consider what type of legislative change may be required, including an examination of any federal laws that may impact such legislation.

We are aware that some members of the community are taking the opportunity presented by this inquiry to propose the introduction of laws which allow doctors to provide assisted dying to terminally ill patients. We often hear about the ‘right’ to die in the context of suffering at the end of life. Such a ‘right’ is not recognized in the majority of countries around the world, with organisations such as the United Nations and the European Court of Human Rights denying it exists. (19) Australian parliaments have rejected 16 euthanasia and assisted suicide bills moved since 2002. In this context, ‘rights’ language is used to convey a strong desire rather than a codified entitlement. While we sympathise with those who suffer, we do not acknowledge their ‘right to die’.

We are all too aware of the distress that can occur in the context of illness and injury, but we see the appropriate response as improved care, particularly improved access to palliative care.
The World Health Assembly passed a resolution recommending universal access to palliative care earlier this year. (20) Palliative Care Australia has identified many areas where access to palliative care is inadequate, including paediatric, geriatric and private health contexts. (21)

Even if the ‘rights’ of the terminally ill to be killed did exist, it would have to be balanced against the needs of the vulnerable patients who would be at risk of being killed without their knowledge or consent, as is now happening in those jurisdictions where euthanasia and PAS are legal. (8)

Australian governments have the responsibility to protect the vulnerable in our society. Autonomy is not an absolute right in law.

In summary, the Christian Medical and Dental Fellowship of Australia acknowledges that there are currently areas of need in end of life care in Victoria, but denies that any change in legislation is required to improve medical care at this most difficult time of life. We attach our position statement on euthanasia which explains our views in more detail.

We would welcome the opportunity to further explain our views to the Committee. All references are available on request.

Yours sincerely

Dr Judy Fitzmaurice
Chair, CMDFA National Board

References

1. Palliative Care Australia. Palliative Care Service Provision in Australia: a planning guide. 2nd ed: Palliative Care Australia; 2003.
19.  Documents such as the United Nations Declaration of Human RIghts and the European Convention on Human Rights do not contain a 'right to die'.