Submission

to the

LEGISLATIVE COUNCIL

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

INQUIRY INTO END OF LIFE CHOICES

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by

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INTRODUCTION

The government has ordered an inquiry by the Legislative Council Legal and Social Issues Standing Committee into whether Victorian laws are adequately meeting people’s expectations regarding medical options available at the end of their life.

The Committee will examine:

- How current medical practices and palliative care can assist a person manage their end of life
- How this issue is managed in other Australian and international jurisdictions
- Potential changes to our legislative framework.

Submissions are to be made by 31 July, 2015.

The Australian Family Association (AFA) is a voluntary, ecumenical, non-party political organisation concerned with strengthening and support of the natural family composed of father, mother and children, in a wider but still necessary relationship of grandparents, grandchildren, aunts, uncles, a kinship group of human beings linked by ties of blood, marriage and adoption. The AFA holds that the family is the basic unit on which human societies are built. The health and wellbeing of every family member affects everyone in the family. When family members face the end of their lives they need the support and care of the family and the family, in turn, needs the support of the laws in place around end of life choices, support in assisting the family member making their wishes known about their care and treatment at end of life and access to good accessible palliative care.

In pursuance of its objectives therefore the AFA has an interest in the matters raised by the inquiry and makes the following Submission.

GENERAL PRINCIPLES

The AFA respects the sanctity of life from conception to natural death and recognises the need for support for all people in need.

In the light of these principles the AFA view is that in the context of end of life care it is palliative care that should be the focus and that deliberately taking the life or hastening the death of a person is undignified and lacking in respect for the person. Palliative care assists people to die with dignity.
SPECIFIC POINTS:

1. PALLIATIVE CARE

Palliative care should be first and foremost in any consideration of end of life choices. If adequate palliative care is not available and accessible then it is not a realistic option in end-of-life care.

a) Availability of and access to palliative care in Australia:

The reality is that not every Australian has reasonable access to palliative care. The Australian and New Zealand Society of Palliative Medicine says that 1.0 full time equivalent (FTE) palliative medicine specialist per 100,000 people is the minimum ratio for a reasonable provision of service. Palliative Care Australia recommends palliative care specialists should be provided to the level of 1.5 FTEs per 100,000 people. Yet the Australian Institute of Public Welfare 2013 report on palliative care services in Australia found that nationally, in 2011, the average ratio of FTE palliative care specialists per 100,000 people was only 0.4. And it varied from state to state and between the city and regional areas. In major cities access was at 0.5 while in outer regional areas it was 0.3 and an even lower 0.2 in inner regional areas. (1)

At present in Australia what palliative care services are reasonably available to a patient varies according to where they live and is in any case availability is below that recommended by peak Australian palliative care bodies.

Adequate palliative care and equity of access regardless of where the patient lives is a serious social justice issue and that needs to be addressed.

Only if adequate palliative care services are available is it a real “choice” in end-of-life care.

b) An agreed understanding of what palliative care is: Palliative care does not include euthanasia or assisted suicide.

The World Health Organisation defines palliative care as follows:

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (2)

Palliative care:
• provides relief from pain and other distressing symptoms;
• affirms life and regards dying as a normal process;
• intends neither to hasten or postpone death;
• integrates the psychological and spiritual aspects of patient care;
• offers a support system to help patients live as actively as possible until death;
• offers a support system to help the family cope during the patients illness and in their own bereavement;
• uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
• will enhance quality of life, and may also positively influence the course of illness;
• is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those
investigations needed to better understand and manage distressing clinical complications.

Bullet points 3 and 4, in stating that palliative care “affirms life” and, in particular, “intends neither to hasten or postpone death”, make it clear that the WHO does not consider euthanasia, which deliberately hastens death, as part of palliative care.

The last bullet point in the definition also makes it clear that the WHO does not consider palliative care as limited to the relief of symptoms only after all therapeutic interventions have failed but should be initiated in conjunction with therapeutic interventions.

Palliative Care Australia has adopted the World Health Organisation definition of palliative care. (3)

**Palliative Care Australia believes: “Euthanasia and physician assisted suicide are not part of palliative care practice.”** (4)

c) **Improvement needed in palliative care:**

The recent *Victorian Auditor General’s Report* on palliative care (5) found that:

“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. “—slightly more community-based palliative care clients died in their preferred place of choice in 2012–13 (64 per cent) compared with 2009–10 (61 per cent). However, despite some initial progress with this important yet challenging goal, it will require sustained effort.”

The AFA supports sustained effort in general towards improvement in the delivery of palliative care and in particular supports funds being made available to increase the availability of home based palliative care to enable all those who would prefer to spend their last days at home to do so.

d) **If euthanasia/assisted suicide were legalised that would undermine the ethic of palliative care and caring for the vulnerable** and there is a danger that there would be reduced investment in improving palliative care by research and clinical trial and reduced investment in increasing the availability and access to palliative care.

Availability and accessibility of palliative care is an essential component of care for those facing death. In Australia the number of full time palliative care specialists is not at the level needed for reasonable provision of service as recommended by the ANZ Society of Palliative Medicine or by Palliative Care Australia. This is a serious issue that needs to be addressed.

Claims that palliative care in the Netherlands and Belgium since legalisation of euthanasia has not lagged behind countries that have not legalised euthanasia state, on the face of the record, that **euthanasia is part of palliative care**. A 2013 report in the European Journal of Palliative Care on palliative care in the Flanders region of Belgium openly reports on “… the growing involvement of palliative care professionals and teams in the accompaniment of euthanasia.” The report also states that: “Today, one in two non-sudden deaths in Flanders occurs with the support of specialist palliative care professionals, whether within mobile home care teams, hospital support teams (which are available in every hospital), hospital palliative care units … or through ‘reference persons
for palliative care’ in homes for the elderly.” (6) Euthanasia is embedded in palliative care in Flanders. The report states that one in two, that is half, 50%, of euthanasia or assisted deaths (“non-sudden deaths” ie planned) in Flanders are facilitated by or carried out by specialist palliative care specialists.
2. **ADVANCED CARE DIRECTIVES:**

The Victorian Law Reform Commission has recommended that:

1. Advance Directives (referred to here as “instructional health care directives”) should be made legally binding.
2. A new offence of medical trespass be created if health providers do not comply.
3. Conscientious objectors whose views or beliefs prevented them from complying should be required to refer the patient to another health professional. (7)

   a) The Catholic Archdiocese of Melbourne in its submission to the Victorian Law Reform Commission enquiry on Guardianship (8) noted that while it supported the appointment of an agent by a patient to make future decisions, it strongly opposed making Advance Directives legally binding because:

   1) **It is unlikely a directive for future events can be supported by informed consent.**

      Except in the case of a degenerative disease with a predictable course, illness is unpredictable so any directive for future events is unlikely to be adequately informed. Questions that arise are whether the circumstances at the time of complying with the directive correspond to the circumstances envisaged at the time it was made; are the treatment and care options available those the patient had in mind at the time of making the directive; are the consequences of implementing the patient’s wishes correspond to what the patient understood would be their consequence at the time of making the directive; have circumstances arisen since making the directive which the patient would have wanted to be considered?”

   2) **Some proposals in advance directives are in fact suicidal,** refusing everything (including food and water) that would keep the patient alive.

      In this way they would seek to bind health professionals to act in a way that would be against their conscience. Further, the VLRC recommendation to create a new offence of medical trespass if health providers do not comply with a directive would mean criminal sanctions for a health professional who could not comply with a directive against his/her conscience.

   3) **Advance directives risk violating the rights to freedom of conscience thought and belief.** Making advance directives legally binding in this way will inevitably create dilemmas around conscience for health professionals and health institutions involved in care of the dying. The VLRC recommendation that a health professional whose conscience means he/she cannot comply with a directive should be required to refer the patient to another health professional does not resolve the issue but in effect replicates Section 8 of the Abortion Law Reform Act, but in the context of the care of dying patients.

   b) **Model ACD Forms:**

      Catholic Health Australia (CHA) in its position statement on advance care planning sums it up very well: “No one … should be compelled to issue instructions about future care, nor should any guidance we leave be too prescriptive.”
Its model form for use as a written record of a person’s health care wishes takes this approach. Planning for end-of-life care ideally should consist of an on-going communication of a person’s wishes rather than a matter of signing a form setting out a list of prescriptive, legally enforceable directions.

The model form states the general principles that the patient wishes to be given appropriate care to sustain life but not treatment that will not sustain life or give comfort or relief or would be overly burdensome; that food and fluid be provided for as long as needed and that, overall, that “I do not want my life ended or my death hastened by any act or omission that is intended to cause death.” This is a life-affirming, positive approach, rightly focussed on “care”. (9)

The Austin Health ACD form (10) also contains an introductory statement that “It is a guide for my future medical treatment*” “… and will be taken into account when determining my treatment.”

However it also provides in the detailed items for the patient to indicate:

- “Specific treatments that I would NOT want considered for me.”

And further items provide:

- “I do NOT want CPR (cardiopulmonary resuscitation), even if the doctors think it could be beneficial.”

- Do NOT want life prolonging treatments at all.”

These blanket refusals of treatment are presented without qualification. Surely whether one would want a specific or life prolonging treatment would depend on how burdensome the person found them at the time the treatment was being considered and on what benefits they would deliver. To refuse treatment for a future condition when the future is unpredictable and the surrounding circumstances unknown is unwise.

To make legally binding a person’s choice not to have treatment at all or even if it could be beneficial would also have serious legal ramifications for representatives and health professionals for whom such a directive would be against their conscience. It would be likely to dissuade a person from agreeing to be a Power of Medical Attorney or a representative for a relative or friend.

Another item that raises questions is that which asks the person to indicate: “Future situations that I would find unacceptable in relation to my health.” Does that mean that, if such a situation arises, all life prolonging care is to cease? Are feeding tubes to be immediately removed? Is dialysis to cease? Are antibiotics not to be continued to treat infection? What are the medical staff caring for that person supposed to do? Are they obliged to cease all treatments or care, such as feeding or treating infection? What is the person’s family/representative supposed to agree to?

Decisions in reality are more nuanced than a bald directive can allow for. If advance care directives were to be made legally binding it would further compound the already existing difficulties of end-of-life care.
c) **How advance care plans should work:**

a. Though illness may be unpredictable, a patient may choose to offer those entrusted with his/her care some guidance about his/her wishes for future health care. For example the CHA model form states “… this document is to be used to inform decisions about my healthcare … This statement is intended to guide but not direct my representative.”

b. Planning future health care relies on good long-term communication between the patient and his/her family, friends and health care professionals. Trust between the patient and his/her representative and/or health care professionals is the basis for such good communication. **That trust would be undermined by seeking to legally bind them to future directives which could raise issues of good medical judgement or conscience for them.**

c. A representative can make health care decisions on behalf of a patient, based on the patient’s advice, the advice of the patient’s health care professionals and the representative’s own good judgement. **These health decisions have the advantage of being flexible in response to changing circumstances. Making ACDs legally binding would not allow this flexibility.**

d. A patient can allow his/her representative to make health care decisions for him/her or can provide the representative with specific advice, verbally or in writing, or by having it recorded in his/her doctor’s records. Again there is **flexibility and a patient can change directions with changing circumstances more easily than if it involved changing a legally binding ACD.**

e. A patient may wish to **clarify the burdens that he/she would find acceptable**, for example by requesting to be given only the kind of treatment or care that can be provided in his/her home, without the need for prolonged hospital care, **rather than categorically state what burdens he/she might find unacceptable.**

d) **View of a doctor working with the elderly**

Dr Karen Hitchcock is a staff physician in acute and general medicine at a major public hospital in Victoria. Earlier this year she wrote an issue of the Quarterly Essay entitled “Dear Life: On Caring for the Elderly.” (11) In an interview on the ABC 7.30 Report she was asked about her view of Advance Care Directives. She said that they are being heavily promoted at the moment as something that should be universally adopted and they do have a place, particularly if people have advanced malignancy and are going to die imminently. However she said they are not a universal answer to caring for people at the end of life: “… to say that they're unambiguously good sort of relies upon an understanding of the human subject that is breathtakingly simplistic. People change their mind. It's very difficult for us to know how we're going to feel as we become increasingly dependent and debilitated.” She gave the example of her grandmother who developed lung disease in her mid-eighties after being very independent until then. Before she developed the disease, which left her housebound and oxygen dependent, Dr Hitchcock said her grandmother would probably have said she would want to die if she found herself in that situation. But when it came down to it she is very happy with her life, with her family and her memories. Asked how she would like to see the debate and discussion about aging and end of life reframed Dr Hitchcock said it should be about
“how can we improve the life of our elderly patients, not that we should be so keen to offer them death.” (12)

Universal adoption of ACDs and making them legally binding would not seem to fit this experienced doctor’s view of how to best care for the elderly as human persons who change their minds like all of us and who, like all of us, may not feel the same way about debility and dependence when we actually experience it as we did in merely contemplating it beforehand.

e) The AFA submits that:

- Advance Care Directives should not be made legally binding. They should not be used as inflexible statements of what treatment the patient will or will not accept but a guide to the patient’s wishes so decisions can be made according to circumstances as they arise.

- If Advanced Care Directives were made legally binding and a person has not updated or changed his/her expressed wishes then the original directive stands and the person may find that his/her doctor is bound to carry out a directive he/she no longer wishes.

- Advance Care Directives should not deny freedom of conscience for health professionals by requiring them to refer directions that would require the practitioner, against his/her conscience, to do any act or omit to do anything that would cause or hasten the death of a patient, to another practitioner with no conscientious objection to the direction.

- Like Birth Plans, Advance Care Plans (ACP) should be flexible as things may not turn out as one thought they would.

- An ACP should be a narrative describing what the person’s most important wishes are in dying and not just a list of medical care/treatment/interventions the person doesn’t want. It should include the things most important for that person such as spiritual, emotional and relational issues eg opportunity to say goodbye to family, a priest or pastor visiting, prayer, opportunity to express real fears of the dying process or what lies ahead.

- Advance Care Directives should be renamed Advance Care Plans to focus on flexibility and allow for the unexpected and be a wish list that covers more than mere refusal of medical treatment.
3. THE LAW SHOULD CONTINUE TO PROHIBIT EUTHANASIA AND ASSISTING SUICIDE

It is not necessary and is undignified and not in keeping with the dignity of the human person, no matter how old or ill or disabled, to deliberately end the life of that person rather than offer medical, palliative, emotional and spiritual care until natural death.

a) Reasons euthanasia/assisted suicide should NOT be legalised:

1. Voluntary euthanasia becomes Involuntary euthanasia: The experience where euthanasia and assisted suicide have been legalised is that the categories of those who can ask for euthanasia or assistance to suicide has been extended. In the Netherlands euthanasia has been extended by practice beyond the provisions of the law to children and in Belgium the original voluntary euthanasia law has been extended to those suffering from dementia and to children (13).

To quote Paul Russell, Director of the organisation HOPE, Preventing Euthanasia and Suicide: “This all points to another reality: that the existence of euthanasia laws creates deep and almost indelible changes to any society where it is legally practiced. What is legal is moral. The law provides boundaries that human nature pushes against almost constantly. Move those boundaries to accommodate the push and, inevitably over time, the push will come against the newly defined boundary. This is the human experience and why, until relatively recently, all societies resisted such changes.” (14)

2. Safe guards have not ever been shown to be adequate.

Wherever euthanasia has been legalised experience has shown the “safe guards” do not work and vulnerable people are therefore at risk. In the Netherlands, Belgium, Luxembourg, Oregon, the record shows that the “safe guards” are often ignored and there is no investigation or any consequences.

The main ‘safe guards’ usually proposed in euthanasia bills are:

- **Voluntary, written request which indicates informed consent.** In the Netherlands despite this “safe guard” more than 500 people are involuntarily euthanized each year (15) Attempts at bringing those cases to trial have failed (16)

- **Mandatory reporting of assisted suicide/euthanasia cases** –Where reporting is required that requirement is often ignored. In Belgium, nearly half of all cases of euthanasia are not reported to the Federal Control and Evaluation Committee (17) In the Netherlands, at least 20% of cases of euthanasia go unreported (18)

- **Second opinion and consultation** - This “safe guard” is meant to ensure that all criteria have been met before proceeding with assisted suicide or euthanasia. However, there is evidence from Belgium, the Netherlands, and Oregon that this process is not universally applied (19) In the Netherlands there is evidence of consultation not being sought in 35% of cases of involuntary euthanasia (20). In Oregon a patient must be referred to a psychiatrist or psychologist for treatment if the prescribing or consulting physician is concerned that the patient’s judgment is impaired by a mental disorder such as depression. In 2007, none of the
people who died by lethal ingestion in Oregon had been evaluated by a psychiatrist or a psychologist (21). Further a 2010 study revealed that among terminally ill patients who received a prescription for a lethal drug under the Oregon assisted suicide/euthanasia law, 1 in 6 had clinical depression and that, of the 18 patients in the study who received a prescription for the lethal drug, 3 had major depression, and all of them went on to die by lethal ingestion, despite having been assessed by a mental health specialist. (22)

- For a detailed examination of whether “safe guards” are effective or adequate. (23)

4. Other reasons for not legalising assisted suicide or euthanasia:

- For 9 years Theo Boer was a member of a regional euthanasia review committee in the Netherlands set up to oversee the operation of the euthanasia law in that country. At first he was in favour of the legislation but now says that, from his experience, legalising assisted suicide is a slippery slope toward widespread killing of the sick. In six years the numbers of deaths doubled. He said: “I used to be a supporter of legislation. But now, with 12 years of experience, I take a different view. At the very least, wait for an honest and intellectually satisfying analysis of the reasons behind the explosive increase in the numbers. Is it because the law should have had better safeguards? Or is it because the mere existence of such a law is an invitation to see assisted suicide and euthanasia as a normality instead of a last resort?” (24)

- The Netherlands Health Minister, Els Borst, who introduced the euthanasia law there in 2002 admitted in 2009 she may have made a mistake in pushing it through because of its impact on services for the elderly. She admitted that medical care for the terminally-ill had declined since the law came into effect and said more should have been done legally to protect people who wanted to die natural deaths: ‘In the Netherlands, we first listened to the political and societal demand in favour of euthanasia,’ said Dr Borst. ‘Obviously, this was not in the proper order.’ (25)

In the UK House of Lords 62 Peers spoke against the 2014 UK assisted suicide/euthanasia bill in 2014. (26)

- **Peak Medical Professional bodies oppose euthanasia and assisted suicide** – euthanasia and assisted suicide are against the codes of ethics of peak medical bodies:

  (a) **World Medical Association (WMA):**

  Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient’s own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness. (Adopted by the 53rd WMA General Assembly, Washington, DC, USA, October 2002 and reaffirmed with minor revision by the 194th WMA Council Session, Bali, Indonesia, April 2013)

  The WMA similarly opposes assisted suicide:

  **Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession.** Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient.
The World Medical Association also passed a specific motion that it: “reaffirms its strong belief that euthanasia is in conflict with basic ethical principles of medical practice; and

The World Medical Association strongly encourages all National Medical Associations and physicians to refrain from participating in euthanasia, even if national law allows it or decriminalizes it under certain conditions.” (27)

After the Second World War, and primarily because of human rights abuses by doctors in Nazi Germany, the World Medical Association adopted two modernised forms of the Oath - the Declaration of Geneva in 1948 and the International Code of Medical Ethics in 1949.

The Declaration of Geneva states, ‘I will maintain the utmost respect for human life from the time of conception’ and the International Code of Medical Ethics says that 'a doctor must always bear in mind the obligation of preserving human life from the time of conception until death.’

(b) The Australian Medical Association: Although it no longer has a position statement specifically on euthanasia it still makes reference to the WMA position statement. (28)

The Australian and New Zealand Society of Palliative Medicine position statement of 31 October, 2013:
“The purpose of this position statement is to state that:
(a) The discipline of Palliative Medicine does not include the practice of euthanasia or assisted suicide;
(b) ANZSPM endorses the World Medical Association Resolution on Euthanasia, adopted by the 53rd WMA General Assembly, Washington, DC, USA, October 2002, which states: "The World Medical Association reaffirms its strong belief that euthanasia is in conflict with basic ethical principles of medical practice, and The World Medical Association strongly encourages all National Medical Associations and physicians to refrain from participating in euthanasia, even if national law allows it or decriminalizes it under certain conditions."
(c) ANZSPM opposes the legalisation of both euthanasia and assisted suicide.”

(d) British professional medical bodies:
“The opposition to euthanasia is strongest amongst doctors who work most closely with dying patients and are most familiar with treatments available. One of our members is the Association for Palliative Medicine of Great Britain & Ireland, which represents over 800 UK specialists in palliative care. Well over 90% of its members are strongly opposed to euthanasia. The British Medical Association (BMA), the Royal College of Physicians (RCP), the Royal College of General Practitioners (RCGP), the Royal College of Anaesthetists, the Royal College of Surgeons of Edinburgh, The Royal College of Nursing and the British Geriatric Society also remain strongly opposed to euthanasia.” (29)
**Views of an palliative care specialist:**

Dr Graeme Duke, a senior specialist in the Intensive Care Department at Box Hill Hospital in Melbourne, expressed his view in an article in the Sydney Morning Herald in May 2014. He wrote: “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.” (30)

**Australian parliaments have rejected 16 euthanasia bills since 2002:**

**New South Wales**
- Voluntary Euthanasia Trial (Referendum) Bill 2002
- Voluntary Euthanasia Trial (Referendum) Bill 2003
- Rights of the Terminally Ill Bill 2013 (defeated in May 2013 in the Legislative Council, 23 votes to 13).

**Western Australia**
- Voluntary Euthanasia Bill 2002
- Voluntary Euthanasia Bill 2010 (defeated September, 2010, 24 vote to 11)

**Victoria**
- Medical Treatment (Physician Assisted Dying) Bill 2008 (defeated September, 2008, 25 votes to 1)

**Tasmania**
- Dying with Dignity Bill 2009
- Voluntary Assisted Dying Bill 2013 (defeated in the Legislative Assembly in September, 2013, 13 votes to 11)

**South Australia**
- Dignity in Dying Bill 2002
- The Voluntary Euthanasia Bill 2006
- Voluntary Euthanasia Bill 2007
- Voluntary Euthanasia Bill 2008
- Voluntary Euthanasia Bill 2010
- Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010
- Voluntary Euthanasia Bill 2012 (defeated on the 14th of June 2012 by the margin of 22 to 20 votes in the Legislative Assembly).
- Medical Defences Bill 2012
SUMMARY:

- Improvements in effectiveness, availability of and access to palliative care are needed to give any credence to end of life “choices.” Improved care, not euthanasia, should be offered to us when facing the end of our lives.

- Legalising euthanasia or assisted suicide would undermine palliative care. It would affect amount of investment of resources in improvements to palliative care if the seemingly easier and cheaper option of euthanasia or assisted suicide were legally available.

- Euthanasia and assisted suicide are not palliative care.

- Euthanasia and assisted suicide are against the codes of ethics of peak medical bodies.

- Experience in countries where euthanasia and assisted suicide has been legalised is that it opens the way to expand the categories of persons who can be euthanised. Voluntary euthanasia becomes involuntary euthanasia.

- Safe guards can never be adequate to protect the vulnerable.

- Australian parliaments have rejected 16 euthanasia and assisted suicide bills moved since 2002.

- Advanced Care Directives should be descriptive, rather than prescriptive. They would be better called Advance Care Plans, which focuses on what is planned rather than setting in writing a legally enforceable directive that a person does not want specified medical care/treatment if a specified health issue arises. As an illness or as age advances a person’s experience of reduced mobility and reduced ability to engage or to deal with the illness or frailness may very well change and they may not make the same decision about refusing medical care/treatment they did when making the ACD.
RECOMMENDATIONS:

- That the government continue to pursue improvements in access to and availability of palliative care.

- That in pursuing improvements in palliative care in Victoria the government take into account all the elements of palliative care as defined by the World Health Organisation to ensure a broad and comprehensive approach to the funding and provision of palliative care.

- That, in view of the findings of the Auditor General’s Report on Palliative Care that palliative care services are struggling to meet the demand for home-based care, the government, in particular, pursue improvements in access to and availability of home-based care.

- That Advance Care Directives be called Advance Care Plans with a focus on planning for what one hopes will happen, not on prescribing what treatment or care is refused.

- That ACDs remain as indicators of the patient’s wishes but not be made legally binding.

- That euthanasia and assisting suicide continue to be prohibited by law.
1. http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129545131 Table 7.3 and Table 7.4


12. http://www.abc.net.au/7.30/content/2015/s4196703.htm


17. “Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases.” Smets T, Bilsen J, Cohen J, Rurup ML, Mortier F, Deliens L, BMJ. 2010 Oct 5; 341():c5174


20. “End-of-life practices in the Netherlands under the Euthanasia Act”, op cit (18)).


27. http://www.wma.net/en/30publications/10policies/e13b/

