27th July 2015

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Building 1, 270 Ferntree Gully Rd
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To The Legal and Social Issues Chair
Parliament House
Spring St, Melbourne VIC 3002
Re: Submission for "End of Life Choices Inquiry"

I wish to make a submission about the issues that the committee is addressing.

End of Life Care and Advanced Care Planning/Directives
I will quote from my textbook 'Murtagh's General Practice (Reference below)
'From a medical viewpoint Advanced care planning (ACP) is not only important
and recommended but rewarding to all parties involved:
The principles are
- recognising the need to prepare for approaching death is an important
  medical skill
- the family needs to know that the patient is dying or that death is inevitable
- ACP is best when the patient is cognisant and involved in the decision
  making
- any advanced care directive should be made by the patient and reflect his or
  her wishes, rather than that of another person
- the health care is primarily patient-centred
- ensure the appointment of Medical Enduring Powers of Attorney for your
  patient
- ACP is best prior to or on admission to the caring facility or 6 months before
  anticipated death-then continuing review
- case conference, ideally with the patient's GP, within this 6 months
- facilitate end-of-life pathway policy prior to death-certainly within the final
  week
- need for agreement for clear goals of end of life care, including resuscitation
  issues
- early referral of terminally ill patients with difficult to control problems,
  especially pain, to a hospice or multidisciplinary team can enhance the
  quality of care

Palliative care
Quality palliative care is fundamental to optimal outcomes for end of life care. It
should continue throughout all phases of terminal illness especially during the
difficult terminal illness. I believe that we have outstanding facilities and palliative
care physicians in Victoria and indeed nation wide. I observe this as I travel the
country teaching post graduate doctors. However there is room for improvement
with the need for more in-patient facilities and better trained rural and remote
doctors. This is being addressed through training by palliative care outreach
services and the GP colleges including the Australian College of Rural and Remote Medicine. Ideally it is best for well trained and or competent GPs to manage these patients as long as possible in the home before admission to the local hospital or nursing home.

Typical case history: this year I had the responsibility as next of kin to care for the welfare of my first cousin—a 74 year old single lady with a long history of cancer of the ovary. She developed bowel obstruction with severe pain and her surgeon and oncologist who had an affiliation with Cabrini Hospital (Maribyrnong) deemed the problem inoperable. Admission was arranged to the Cabrini Hospice in Prahran under the care of Associate Professor Natasha Michael. I observed her care for 5 weeks prior to her death and she was kept pain free, comfortable and lucid with the skillful use of morphine and the tranquiliser-haloperidol. The Pastoral services team of Cabrini Palliative Care provided ongoing support for the patient and myself and other family members. This was a ideal scenario and one would hope that this type of service was the norm.

The question of euthanasia

Once again I quote from my textbook

"it should be an uncommon experience to be confronted with a request for the use of euthanasia, especially as the media clichés of 'extreme suffering' and 'agonising death' are uncommonly encountered in the context of attentive whole-person continuing care. The non-use of life support systems, the use of 'round the clock' morphine, the use of ancillary drugs such as anti-depressants and tranquilisers, various nerve blocks and loving attention almost always help the patient cope without undue pain and suffering"

Case history: Brian, aged 63, was a friend of mine who developed motor neurone disease. He left work and was cared for at home by his wife with the help of his GP and eventually by the Bethlehem Hospice outreach program. He suffered from the typical discomforts of the disease and I did ask him his thoughts on euthanasia. He totally rejected the notion stating that he wanted to be with his family as long as possible. He developed a urinary infection and was admitted to Bethlehem where he said he was receiving excellent care. However he deteriorated suddenly and died from septicaemia. The message here are the value of being cared for at home, euthanasia is not the answer and that death can come suddenly and unexpectedly to any terminal ill patient (examples I have seen are heart attacks, stroke, seizure, kidney failure and sepsis).

For many logical reasons including my physician mantra of respect for human life I am opposed to euthanasia and above all, physician assisted suicide. As medical practitioners we can work comfortably within the present laws. It is worth noting that attempts to introduce laws legalising euthanasia on demand have been rejected 24 times in Australian parliaments. We certainly don't need a 'licence to kill' or be subject to a law that does not allow us to follow our conscience and/or best medical judgment.

John Murtagh MD, AM
Emeritus Professor of General Practice.