



Coalition for the Defence of Human Life
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The Principal Research Officer
Joint Select Committee on End of Life Choices
Legislative Assembly
Parliament House
Perth, WA 6000

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Dear Chair and Members of the Joint Select Committee on End of Life Choices,

Thank you very much for the invitation to make a submission to the Inquiry into the need for laws in Western Australia to allow citizens to make informed decisions regarding their own end of life choices.

The Coalition for the Defence of Human Life (CDHL) is a non-party political association comprising of fifteen member organisations (listed at the end of this submission). The CDHL exists in order to promote, preserve and defend the sanctity of human life from fertilisation to natural death; oppose the destruction of human life by abortion, infanticide, euthanasia and experimentation; encourage organisations which share in the stated objects; and to engage in campaigns, projects and other activities in order to achieve these objects.

The CDHL is very concerned about the possibility of laws in Western Australia which could see the legalisation of euthanasia and assisted suicide, and is strongly opposed to the introduction any such legislation.

Defining the issues

The language surrounding euthanasia and assisted suicide is often vague, euphemistic and misleading as to the reality of the true nature of what is being discussed.

Euthanasia refers to the deliberate action of a medical professional (e.g. administering an injection) which has the deliberate intention of ending the life of the patient.

Assisted Suicide occurs when a person is given assistance by a medical professional to end their own life (e.g. by providing a prescription for certain lethal drugs).

Both of these actions are deliberately intended to cause the death of the person concerned. As such, these are lethal actions which are in direct contradiction with the nature and ethos of the

healthcare profession, which is to heal, care for, nurture and preserve all human life, not to intentionally cause its premature ending.¹

Terms such as 'dying with dignity', 'physician assisted death' and 'medical aid in dying' cause confusion between the actions of caring for people, and killing them. The Coalition affirms that all people should receive the proper medical assistance at the last stages of their life which upholds their inherent dignity. This is not to be confused with the fatal acts of euthanasia and/or assisted suicide.

Another distinction which must be made is between that of ordinary and extraordinary medical care. Ordinary care refers to the provision of basic human needs, such as food, water, shelter and physical comfort (including pain relief). Because these aspects of care are fundamental human rights, it would be gravely immoral to deliberately withhold them from any person at any stage of life.

Sometimes, when a person is experiencing high levels of pain at the end of their life, large doses of drugs (such as morphine) are necessary to relieve the person's suffering. In some cases, the administration of such drugs may have the consequence of hastening the death of the patient. However, this cannot be considered a form of euthanasia. First of all, the intention of the medical professional is to eliminate the suffering a person is experiencing, not the sufferer themselves. The fact that death occurs a little earlier than it would have otherwise is not desired, but accepted as an unwanted side effect. Also, it must be said that such treatments do not so much cause death, as are a contributing factor. The effective cause of death is the condition the patient was suffering from, not the intervention of those caring for them.

Extraordinary care refers to other medical treatments which are intended to cure or minimise the effect of specific illnesses and conditions which a patient may be suffering from. When a person is naturally drawing towards the end of their life, many forms of extraordinary care would be considered unnecessarily burdensome, i.e. cause greater difficulties and suffering for the patient than any benefit gained from it. The ethical and legal prohibitions which prevent the deliberate taking of a human life do not mean that human life must be preserved at all costs. In such cases, discontinuing, or not commencing, such extraordinary treatment is NOT 'passive euthanasia', rather, it is good medical practice to recognise when a person is naturally approaching the end of their life, and assist them (through the appropriate provision of ordinary care) to manage the last stages of life with as little suffering as possible.

Euthanasia and Assisted Suicide: Why not?

There are many reasons why the Coalition for the Defence of Human Life urges the Parliament of Western Australia to reject the proposition of legalising euthanasia and/or assisted suicide in our state.

Firstly, euthanasia and assisted suicide are at their core murderous acts because they deliberately and directly cause the death of the patient. The Coalition is of the conviction that the right to life is the

¹ See, for example: World Medical Association, *WMA Resolution on Euthanasia*, (April 2013), <https://www.wma.net/policies-post/wma-resolution-on-euthanasia/> (accessed 19/10/2018); Australian Medical Association, *AMA Position Statement: Euthanasia and Physician Assisted Suicide* (2016), <https://ama.com.au/system/tdf/documents/AMA%20Position%20Statement%20on%20Euthanasia%20and%20Physician%20Assisted%20Suicide%202016.pdf?file=1&type=node&id=45402> (accessed 19/10/2017)

first and most important of all human rights, and that every human life has intrinsic dignity and value. There is nothing we can do, and nothing which could ever happen to us which can alter in any way the fact of us being a human person. Our dignity is found in the inherent fact of our being human, not arbitrary concepts such as 'autonomy', 'independence' or 'quality of life' which are often subjectively measured by the individual concerned and subject to great variance. People do not 'lose their dignity' in the face of death, pain, incapacitation, dementia, incontinence, or any other such limitations and challenges. Ironically, euthanasia and assisted suicide deny true human dignity, by reducing it to a subjective concept measured by categories based on a person's current perception. As such, they are actions which can never be considered as right, just or even acceptable.

In effect, what the legalisation of euthanasia and assisted suicide does is create exceptions to our homicide laws, where some people are given the endorsement of the law to kill another person, or to assist them to kill themselves. If euthanasia and/or assisted suicide were to be made legal in Western Australia, we would establish a double standard in our society, where we have class of people deemed as 'killable', whose lives are not considered to be not worth protecting. This situation is as abhorrent, dangerous and inhuman as it sounds.

The most powerful argument used by proponents of euthanasia and/or assisted suicide, is that these practices are necessary to prevent people dying in unbearable pain. The Coalition for the Defence of Human Life agrees that we should be working to minimise pain and suffering for people in the last stages of life. However, according to medical professionals who work most closely with dying patients, pain can be adequately dealt with and therefore euthanasia is simply not necessary.

In a detailed submission to the recent Inquiry of the Victorian Parliament into End of Life Choices, Palliative Care Victoria explains in some detail:

"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. Where these symptoms are not readily alleviated by general health and care services, a referral to access the specialised expertise of palliative care services should be made. In most cases, specialist palliative care teams are able to address the person's physical pain and other symptoms and to respond to their psycho-social, emotional, spiritual and cultural needs so that they are able to live and die well with dignity. However, a small minority of patients experience refractory symptoms such as agitated delirium, difficulties breathing, pain and convulsions.

Refractory symptoms are defined as:

"pain or other symptoms for which all possible treatment has failed, or it is estimated that no methods are available for palliation within the time frame and the risk-benefit ratio that the patient can tolerate."

A patient with refractory (unrelieved) distress "must have received skilled multidimensional management directed at the physical, psychological and existential dimensions of the symptom before a symptom is considered refractory." Prudent application of palliative sedation therapy may be used in the care of selected palliative care patients with otherwise refractory distress.

[T]he level of sedation used should be the lowest necessary to provide adequate relief of suffering: "The doses of medications should be increased or reduced gradually to a level at which suffering is palliated with a minimum suppression of the consciousness levels and undesirable effects, with documentation of the reason for changes and response to such manoeuvres." Only under exceptional circumstances is deep and continuous sedation required from initiation of palliative sedation therapy."²

² Palliative Care Victoria, *Submission to the Legal and Social Issues Committee: Inquiry into End of Life Choices* (July 2015),

Furthermore, in an open letter to the Members of the Parliaments of Victoria and New South Wales, one hundred and five palliative care professionals refuted the “false belief” that good palliative care “cannot assist or support those with pain and suffering in a professional and ethical manner”³; while recently three former presidents of the Australian Medical Association Victoria affirmed that “When it comes down to it, if you provide the right palliative care urgently, effectively and confidently, you don't have to have the sorts of deaths that proponents of this legislation are suggesting you can't avoid.”⁴ The excellent standard of modern palliative care means that no-one, especially in such an affluent society such as ours, has any reason to die a painful and/or distressing death. Wherever there is great suffering at the end of life, the questions we should be asking are not along the lines of, ‘how sick does a patient have to be before we kill them?’, rather, we must be asking, ‘how can we provide the care which is needed in this situation?’.

However, experience from overseas indicates that in reality, the experience of ‘unbearable’ pain – or even the fear of its potential occurrence at some later stage – is not, in fact, the main reason why people seek medical assistance to end their lives. In the brief period where euthanasia was legalised in the Northern Territory, none of the seven patients who died by the hand of Dr. Philip Nistchke were experiencing uncontrolled pain.⁵ According to a study published in the journal *JAMA Oncology*, between the years 1998 and 2015, of the 991 people in the state of Oregon, USA, who died by medically assisted suicide, 91.6% indicated they wanted to die because of ‘losses of autonomy’, while 89.7% reported that ‘activities of daily living were not enjoyable’ and 78.7% were concerned about loss of dignity, while pain control was a factor in only 25.2% of cases.⁶ Other studies indicate that depression is a major factor which may cause the desire for a hastened death.⁷ The reality is that most people who seek euthanasia, do so because they perceive they have lost their sense of dignity, or enjoyment of life. In such cases, offering to help a person die is not an appropriate response. Rather, we must give them the dignified care and support they need to live a meaningful life.

While death by euthanasia is often marketed as guaranteeing a calm, peaceful death which is a good experience for all involved, this is not a realistic picture. The means by which a person is killed, do not always work as intended. A study from the Netherlands found that up to one-quarter of people

https://www.parliament.vic.gov.au/images/stories/committees/lsc/Submissions/Submission_236_-_Palliative_Care_Victoria.pdf (accessed 18/10/17)

³ *An Open Letter to the Members of Parliament by Australian Palliative Care Professionals* (25/09/2017), http://www.no euthanasia.org.au/letter_members_parliament_australian_palliative_professionals (accessed 18/10/2017)

⁴ “Former AMA Victoria Presidents urge MPs to reject euthanasia legislation”, *ABC News* 19/09/2017, <http://www.abc.net.au/news/2017-09-19/ama-presidents-pressure-victorian-mps-to-reject-euthanasia/8957800> (accessed 18/10/2017)

⁵ Ezekiel Emanuel, “Euthanasia and physician-assisted suicide: focus on the data”, in *Medical Journal of Australia*, 2017; 206 (8): 339-340

⁶ Charles Blanke, Michael LeBlanc and Dawn Hershman, “Characterising 18 years of the Death With Dignity Act in Oregon”, in *JAMA Oncology* 2017;3(10): 1403-1406. Tragically, this study also found that 3% of those who died by assisted suicide did so because the cost of chemotherapy was too high.

⁷ See, for example, Herbert Hendin, *Seduced by death: Doctors, Patients and Assisted Suicide* (New York: WW Norton, 1998), p 34-35; William Breitbart et al, “Depression, Hopelessness, and the Desire for Hastened Death in Terminally Ill Patients With Cancer” in *Journal of the American Medical Association*, 13/12/2000 p. 2907-2911.

who attempt to die by assisted suicide experience some form of complication or problems with completion, including vomiting, gasping, psychosis, seizures, muscle spasms and awakening from induced coma.⁸ Although death by euthanasia and/or assisted suicide usually occurs quickly, data from Oregon, USA, shows that death can take over four days to occur after ingesting the prescribed 'medicine'.⁹

The practice of euthanasia and/or assisted suicide also has considerable negative effects for other people involved, beyond the individual concerned. In the Canadian province of Ontario, within eight months of euthanasia being legalised in that country, 54 doctors had removed their name from a list of willing providers, leaving only 137.¹⁰ Many of these doctors ceased to be involved in the practice because of the moral and psychological distress of killing another human being. One study examining family members or close friends who were present for the death of a loved one by assisted suicide found that 20% had full or subthreshold Post Traumatic Stress Disorder, while 16% had depression.¹¹

Even if one believed that euthanasia and/or assisted suicide was an appropriate option in some circumstances, the overall negative effects it would have in society far outweigh any 'benefit' it may offer to a few.

Making the option of euthanasia and/or assisted suicide, by its very nature devalues the worth of human life, and especially the life of those who are sick or disabled. It imparts an implicit message to some of the most vulnerable people in society, that their life is not worth living, and that 'topping yourself off' is a rational and valid response to the situation they find themselves in. Not only that, but the medical profession will provide all the assistance that one would need. Many older, chronically ill and disabled people already struggle and have to fight hard for others to see their lives as valuable, and not just a 'burden' on society. Euthanasia and/or assisted suicide will entrench these discriminatory and dehumanising attitudes towards the elderly, sick and disabled in our society, and open the door to increases in all forms of abuse towards such people. Because of implicit or explicit pressure from others, the 'right to die' will become for many people a 'duty to die': a duty to cease being a burden and drain on society's resources, a duty to get out of the way so that others can get on with their lives, to choose death rather than proper medical treatment. Concerningly, almost half of all people who died by assisted suicide in the US state of Oregon last year, cited 'being a burden on family, friends, and/or caregivers' as a reason which made them want to end their life.¹²

In addition, there is evidence that the practice of euthanasia and/or assisted suicide actually increases the overall suicide rate. In Oregon, which legalised assisted suicide in the late 1990s, the

⁸ JH Groenewoud et al, "Clinical problems with the performance of euthanasia and physician-assisted suicide in The Netherlands", in *The New England Journal of Medicine*, 24 February 2000, 342 (8): 551-556.

⁹ Charles Blanke, Michael LeBlanc and Dawn Hershman, "Characterising 18 years of the Death With Dignity Act in Oregon", in *JAMA Oncology* 2017;3(10): 1403-1406.

¹⁰ Sharon Kirkey, "'Take my name off the list, I can't do any more': Some doctors backing out of assisted death", in *National Post*, 27/02/2017.

¹¹ B Wagner, J Muller and A Maercker, "Death by request in Switzerland: posttraumatic stress disorder and complicated grief after witnessing assisted suicide", in *European Psychiatry*, Oct 2012 27(7): 542-546.

¹² Oregon Health Authority Public Health Division, *Oregon Death with Dignity Act: Data Summary 2016* (10 February 2017)

suicide rate is now 41% higher than the national average.¹³ This is not surprising, as the practice of euthanasia and/or assisted suicide sends the message that suicide is an appropriate and acceptable response to suffering, and normalises this most tragic of actions. We are already investing many resources towards lowering the suicide rate, because of the trauma and disastrous societal consequences it causes. Let us not undermine these most important and commendable of efforts, which keep the very fabric of our community intact.

The ‘slippery slope’ effect is also a serious reason to not legalise euthanasia and/or assisted suicide. While at first, these methods of physician assisted death may be legalised within very specific parameters, there will always be some people who wish to die, but fall just outside these boundaries. Legalising euthanasia and/or assisted suicide sets a dangerous precedent, that when one considers their life not worth living, they should receive assistance to end it. If euthanasia and/or assisted suicide is available for someone who is expected to die within the next six months, there is no good reason to deny it to another person who is ‘ready to die’, but has an estimated eight months of life ahead of them – or twelve, or eighteen, or twenty-four. In the same manner, if we are going to offer to help someone die because they have an incurable physical disease, why not a psychiatric condition which causes them ‘unbearable’ suffering? After all, people experiencing these conditions can endure even greater and more prolonged suffering than is caused by many physical illnesses. In the Netherlands and Belgium, there is a growing trend of people seeking euthanasia for psychiatric disorders, or even for simply being ‘tired of life’.¹⁴

Furthermore, there is evidence that euthanasia and/or assisted suicide is already occurring, despite being illegal.¹⁵ Some will say that legalising these practices will serve to ensure they are properly regulated and overseen, protecting vulnerable people. However, as the Minority Report of the Inquiry into End of Life Choices commissioned by the Victorian Government observed of places where euthanasia and/or assisted suicide had already been legal for some time:

“There is a widespread failure of safeguards and procedures across jurisdictions, including low rates of reporting. While legalisation was supposed to bring what was occurring in the shadows into the light, legalisation has simply pushed the boundary of what is legal out further and may have increased the amount of activity that occurs beyond the sight of regulators.”¹⁶

Legalising euthanasia and/or assisted suicide does not make it safe: it makes it acceptable in all forms, not just those which are arbitrarily legal.

If assisted suicide is legalised, there is also the added danger of the misuse of prescribed drugs. In Oregon, only two thirds of people who were prescribed ‘medication’ to end their life, died by this method.¹⁷ Of those who did use the medication, a many waited a significant amount of time before taking it. What happened to the drugs which were not ingested for the intended purpose is simply not

¹³ Lynne Terry, “Study: Oregon patients using physician-assisted suicide steadily increase”, *Oregon Live* 6 April 2017.

¹⁴ Senay Boztas, “Netherlands sees sharp increase in people choosing euthanasia due to ‘mental health problems’”, in *The Telegraph*, 11 May 2016.

¹⁵ Julia Medew, “Don’t-tell doctors supporting secret euthanasia deaths”, in *The Sydney Morning Herald*, 7 September 2014.

¹⁶ Daniel Mulino, *Minority Report of the Victorian Parliamentary Inquiry into End of Life Choices* (June 2016).

¹⁷ Charles Blanke, Michael LeBlanc and Dawn Hershman, “Characterising 18 years of the Death With Dignity Act in Oregon”, in *JAMA Oncology* 2017;3(10): 1403-1406.

known. This creates a situation where there is the serious potential for the abuse of such drugs, with tragic consequences.

As already mentioned, euthanasia and assisted suicide is in direct opposition to the ethos and *raison d'être* of the medical profession, which is to provide timely and appropriate medical care for people, not to kill them.¹⁸ To have doctors and nurses providing euthanasia and/or assisted suicide, would change the very nature of the medical profession, from being advocates for life, to that of being dispensers of death. Killing people should never be offered as an option instead of caring for them, or confused together. There is anecdotal evidence that in Holland, many elderly people now avoid going to hospital, for fear of being euthanised.

In particular, the introduction of euthanasia and/or assisted suicide would be a cause of alienation between the medical profession and Indigenous peoples in Western Australia. This would have tragic consequences for these members of our society, who already experience much higher rates of chronic and preventable illness, as well as a much lower life expectancy than the general population.

In 1997, shortly after the Commonwealth 'Euthanasia Laws Act' had been passed, ending the period in which euthanasia was legal in the Northern Territory, activist Chips Mackinolty who had been leading an education program about the Rights of the Terminally Ill Act among Indigenous people, declared:

"I personally support my having access to euthanasia - but not in the Northern Territory. It is arguably the right legislation - but certainly in the wrong jurisdiction. ... Whether the legislation is good or bad for us, as whitefellas within our own cosmology, is immaterial. I believe the very existence of the legislation poses an unacceptable risk to the health of Aboriginal Territorians who may delay or refuse to access health care because of fears they have of the legislation. Those fears are deeply embedded in Aboriginal world views. Put simply, it has the potential to lead to premature deaths amongst a group of people whose life expectancy is already unacceptably low... While this law remains on the books in the Territory, it will continue to pose this threat to Aboriginal health. This threat will continue for a very long time to come if Aboriginal world views about health and illness, life and death persist — and the evidence to date is that those world views have already persisted for a substantial period despite long-term contact with non-Aboriginal world views. This persistence of such world views is not amenable to 'education programs' in general — let alone the kind contemplated and carried out as part of the ROTI legislation education program — no matter how much support and good will is afforded by such a program. People, no matter what their cultural background, do not 'unlearn' their world view so easily. I do believe that there are very real risks to the health of Aboriginal people, by virtue of the existence of the legislation ... Frankly, I do not think Aboriginal people need another potential 'agency', let alone 'cause', of death."¹⁹

The practice of euthanasia and/or assisted suicide is one which is directly contrary to Indigenous culture, which emphasises connection to the land and embracing the natural rhythms of life. The presence of laws making such practices available, will add to cultural barriers between 'blackfellas' and 'whitefellas', and have the effect of causing mistrust and misunderstanding between Indigenous persons and the medical profession. This would be an unacceptable step for our society to take.

¹⁸ World Medical Association, *WMA Resolution on Euthanasia*, <https://www.wma.net/policies-post/wma-resolution-on-euthanasia/> (accessed 19/10/2018).

¹⁹ Chips Mackinolty, "Right Legislation: Wrong Jurisdiction?", in *Alternative Law Journal*, Vol. 22 (2), pp. 68-71 (April 1997).

Providing Truly Compassionate Options

If a person is opposed to euthanasia and/or assisted suicide, it is unfair and unjust to accuse them of 'not caring if people die undignified death'. Rather, is it out of compassion and a deep respect for the dignity of the individual, that those who are most opposed to euthanasia and/or assisted suicide are also among the most vocal advocates for making gold-standard palliative care available to everyone.

We are most fortunate to have the second best system of palliative care in the world, which can provide support and effective management of all the challenges associated with the last stages of life.²⁰ If all people knew of the services which are available, and had the means to access them, there would be few if any calls for the legalisation of euthanasia and/or assisted suicide. However, significant barriers exist between many people and the end-of-life care they need.

Earlier this year, a media release by Palliative Care Australia voiced concerns about inequity in access to palliative care across Australia.²¹ In particular, Palliative Care Australia highlighted the fact that people living in regional areas have less access to palliative care options. In particular, home-based palliative care services are lacking in rural and regional locations. At the same time, regional hospitals only employ half as many specialists in palliative medicine relative to population as hospitals in major cities, further compromising the level of care that country residents can receive.

Even in urban centres, the availability of palliative care options is often limited by socio-economic status ('postcode medicine'), with a disproportionate number of hospice facilities in more affluent areas. In addition, many home-based palliative care services are only available to those who are able to afford them, resulting in significantly larger rates of unnecessary palliative care hospitalisation among people of lower socio-economic status.

Perhaps most tragically, further barriers to accessing palliative care exist for many people because of the lack of awareness regarding palliative medicine among the wider medical profession.²² Many doctors are not particularly skilled in recognising when a person is naturally approaching the end of their life, and so continue to pursue futile and burdensome treatments, and/or are simply unaware of the full capacities of palliative care.

Over the past decades, the ability of palliative care to assist people to die in comfort and peace has been significantly increasing. Symptoms such as pain and distress can be effectively managed, while emotional and spiritual support can ensure it is a peaceful and positive experience for the dying person and their family. However, it seems that there are many people in our state who are needlessly missing out on end-of-life care which is effective, holistic and truly dignified.

There is a real inequality among the options and services available to some of the most vulnerable members of our community, the sick and elderly. The Coalition for the Defence of Human Life believes

²⁰ *The 2015 Quality of Death Index: Ranking palliative care across the world*, The Economist Intelligence Unit, 2015

²¹ Palliative Care Australia, *National health statistics highlight inequitable access to palliative care* (Media Release), 24/05/2017

²² David Brooks, "Doctors are still not good at talking about dying", in *The Guardian*, 15 May 2014.

it is important that this Committee give serious consideration in regards to what must be done to ensure all people, not just wealthy city-dwellers, receive high quality end-of-life care.

Yes, this standard of palliative care does come at a significant financial cost. However, it must be considered as a priority by the government, as it is a necessary service if all people are to navigate the last days of life in a way which is truly dignified. Of much greater human cost to our society would be the effects of passing laws which would see euthanasia and/or assisted suicide legalised in our state.

Yours Sincerely,

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Research Officer

The Coalition for the Defence of Human Life

Representing the following organisations:

- 40 Days for Life Perth
- Association for Reformed Political Action
- Australian Christian Lobby
- Australian Christians
- Australian Family Association
- Christian Reformed Churches
- Endeavour Forum
- FamilyVoice Australia
- Helpers of God's Precious Infants
- Life Ministries Inc.
- Medicine With Morality
- National Civic Council
- Pregnancy Assistance
- Westminster Presbyterian Church