

Submission to the Joint Select Committee on End of Life Choices

We wish to comment on the Inquiry into End of Life Choices. As a doctor and final year medical student, we have both had many opportunities to interact with people at the end of their lives, including a compulsory palliative care term as part of our medical degrees.

The end-of-life period is a difficult time for patients and their families. There are often uncertainties as to life expectancy, the symptoms that will be experienced during the terminal phase, how the family will respond following the passing of their loved one, and for the patient themselves, uncertainties about what lies after death.

Currently, patients identified as being at the end of their lives can be referred to a palliative care team, at the patient's request. These teams consist of doctors, nurses and other allied health professionals who aim to control the patient's symptoms and allow the end-of-life period to be as pain-free, peaceful and dignified as possible. Through combinations of pharmacological and non-pharmacological means, palliative care teams are able to minimise the suffering of patients at the end of their lives, while still affirming the sanctity of human life.

We are concerned by any efforts to legalise euthanasia or physician assisted suicide in Western Australia. Any treatment which deliberately hastens death devalues human life. It sends the message to patients with terminal illnesses that their situation is too hard for the medical profession and society more broadly to deal with and that it would be better if they weren't alive at all. This raises two concerns. Firstly, this is not an attitude we want our society to adopt. We need to hold human life with the highest esteem. Allowing euthanasia or physician assisted suicide erodes this esteem. As has been seen in other countries where these practices are permitted, it is opened to more and more people. For example, in Belgium, mentally ill people can be euthanased. These are people whose illnesses are not terminal, and with appropriate support and treatment, can contribute to society. The second concern the prospect of euthanasia and physician assisted suicide raises is more personal, namely, being asked by a patient to facilitate their death. This request goes against the oath taken at the commencement of our careers, that "The health of my patient will be my first consideration" and "I will maintain the utmost respect for human life." Euthanasia and physician assisted suicide stand in direct contrast to these statements. As doctors, we want our patients to know that we are doing all we can look after them and improve their quality of life. There is an inherent power imbalance in the doctor/patient relationship and doctors can use their knowledge and position to guide patient decision making. Patients trust their doctors to give them advice in-keeping with their best interests. This trust is broken when doctors are able to end life, as the patient can no longer be sure that their doctor isn't just suggesting the hastening of death as an easy

alternative.

It is important to draw a distinction between euthanasia and physician assisted suicide (that is, deliberately hastening death) and withdrawing or not initiating life prolonging measures. We have both seen many instances where to continue to provide life prolonging treatment to someone with a terminal illness would have resulted in a reduced quality of life for the patient. We see no ethical issue with withdrawing or not initiating life prolonging treatment in this setting, as the body is allowed to die naturally. This contrasts with euthanasia and physician assisted suicide, where a drug is given with intent of deliberately hastening death.

We thank the Committee for this opportunity to comment on the Inquiry into End of Life Choices.

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