

## Admin, LACO

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**Subject:** FW: Submission: End of Life Choices

**From:** Kara-Leigh VanderVen

**Sent:** Tuesday, 10 October 2017 3:57 PM

**To:** Joint Select Committee on End of Life Choices <[eolcc@parliament.wa.gov.au](mailto:eolcc@parliament.wa.gov.au)>

**Subject:** Submission: End of Life Choices

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

As a resident of Western Australia and an Occupational Therapist working within the Western Australia public health system, I am writing to express my concern about the possibility of assisted suicide and/or euthanasia becoming legalised in our state. The reality is that physician assisted death is both unnecessary, and unsafe.

Euthanasia and assisted suicide is a dangerous option for vulnerable people. Many elderly, chronically ill people, and people with disabilities already feel they are a 'burden' on their family and marginalised by society. This feeling of 'burden' on families and society has been evident in these groups of people throughout my work. As an Occupational Therapist, I have worked on medical, rehabilitation and surgical wards of hospitals, in addition to outpatient memory and falls clinics and home visiting teams to enable people to maintain their independence and quality of life in everyday activities. Due to the nature of Occupational Therapy I work primarily with these vulnerable people. It is common to hear elderly people in hospital with life limiting conditions (e.g. Parkinson's Disease, organ failure, cancer etc.) or physical infirmities (e.g. broken bones, immobility, incontinence etc.) express guilt over the amount of care family must provide. Just last week in my outpatient memory clinic one lady, who in all likelihood will be diagnosed with the terminal condition of dementia, told me quite emotionally "[my husband] didn't sign on for this...when you marry you don't think of what will happen when you're old and what you may be expected to take on...it's not fair for him". Rather than affirming the value of every person to our society, even presenting the legal option of physician assisted death for frail and dependent people further embeds the idea that they are 'better off dead' and their lives not worth living.

In addition to promoting the idea that these vulnerable people are worthless to society, I am greatly concerned that the legalisation of euthanasia and assisted suicide will lead to many vulnerable people being killed against their wishes. Although there may be laws, policies and procedures put in place to try and assure us that this will not happen, there will still be a multitude of 'grey areas' facing the medical teams and physicians responsible for making the final decision. Hospital and medical staff, especially on aged care wards are so often faced with difficult social situations where it is impossible to determine the best decision for the patient. In my experience, it is a regular occurrence to be faced with families who are fighting over an elderly parent's money; family members who have not spoken in years but suddenly present a vested interest into their parent's well-being; patients who have been left homeless by family members who do not want their parent to be living with them any longer; patients who are left in emergency rooms by family, with conditions such as dementia, cancer etc. where it is difficult to determine the patients' wishes; husband and wife who present to hospital, both with undiagnosed dementia, no family support, no Advanced Health Directives/EPOA/EPOG, and are unable to care for themselves. These situations only cover some which I encounter in everyday work, and I have serious doubts that in every situation the physician's decision for/against euthanasia would be in line with the person's wishes. Legalising assisted suicide and euthanasia places the lives of these already extremely vulnerable people into the hands of medical staff, and devalues their personhood and place in society.

One of the terms of reference of the Joint Select Committee is to 'examine the role of Advance Health Directives, Enduring Power of Attorney and Enduring Power of Guardianship laws and the implication for individuals covered by these instruments'. In my experience, there is not enough knowledge within the elderly population about these instruments. Often, it is not until the idea of AHDs, EPOA, or EPOG are raised with a patient or family by medical teams or social workers that one is setup. Usually before this point in time a patient does not even understand what these instruments are. Further, as I alluded to in my previous paragraph, it happens on a weekly basis that someone presents to hospital and is assessed as not having capacity to make decisions by a Psychiatrist or Geriatrician, but

also has not appointed an EPOA or EPOG. An application is required to be made to the State Administrative Tribunal (SAT) by a social worker, and the patient must either remain in the hospital until a hearing date is appointed or, in more complicated social situations, the patient will remain in hospital for weeks to months to await their hearing date. From the hearing, a guardian and/or administrator may be appointed from family or by the state. This process is a monumental waste of hospital funding and resources. Additionally, to say that the right person is appointed each time by the SAT as guardian or administrator, and that that person will always make decisions in the patients' best interests is naïve. Here again a situation is created where, if euthanasia and assisted suicide is legalised, vulnerable people are placed at risk. If only one person is killed against their wishes through euthanasia or assisted suicide, it is one too many.

Finally, another of the Joint Select Committee's terms of reference is to '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 when experiencing chronic and/or terminal illnesses'. I would like to take this opportunity to provide you with my positive experiences of the current practices surrounding palliative care. When someone with a life limiting condition attends hospital, one of the first pieces of paperwork that is completed by the medical team is the 'Physician Orders for Life-Sustaining Treatment'. This document is completed with the patient and/or family members so that a ceiling of care is established which meets the patient's wishes, and I can only think of several instances during my experience where this document has not been completed. Further, a patient with a life limiting condition is almost always seen on the ward by the Palliative Care team, consisting of the Pain Specialist, Palliative Care Nurse and Palliative Care Consultant, regardless of how imminent death may be for the patient. This means that a long-term plan is also established for the patient, also once they leave hospital. Having the Palliative Care Team involved also helps to keep the general medical team from completing interventions, prescribing medications etc. which are not helpful for the patient given their condition, since the Palliative Care Team work closely alongside the general medical team.

Additionally, if someone is in the final stages of their condition, much effort is put into meeting the person's wishes for their death. If they desire to return home, the entire Multidisciplinary Team work hard to provide the equipment, services, pain management and support so that this person can return home. One service we regularly refer to is Silverchain Hospice, which can provide all the care, support and equipment a person will require for the final days of their life. Unfortunately, these services are limited by funding, so that they cannot always accept every person that is referred, and this should be an area of consideration by the Joint Select Committee. If a person or their family have chosen for the person to die in hospital, I have seen firsthand the effort put in by the medical team and nursing staff to manage pain, provide comfort, maintain hygiene and dignity, and support the family. It was a regular occurrence for the ward to receive cards of thanks from family, following the death of a loved one, due to the level of care that was provided.

Therefore, in concluding my submission, the legalisation of euthanasia and assisted suicide will undeniably devalue the vulnerable people within our society and place them at extreme risk. Instead, we need greater awareness of and resources for palliative care services, so that all people can access the medical, pastoral and spiritual care they need at the end of their life. This is the only truly humane and dignified response.

Regards,

Kara-Leigh Visser  
Occupational Therapist