

Submission to the Joint Select Committee on End of Life Choices

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From **Professor Michael Francis Quinlan**

Background of Professor Michael Francis Quinlan LLD, MBBS, MD, FRACP

- Consultant General Physician
- Professor of Medicine – University of Notre Dame Australia (UNDA)
- Clinical Professor of Medicine – University of Western Australia (UWA)
- Foundation Dean for the UNDA College of Health: responsible for the foundation of the Schools of Medicine, Nursing and Physiotherapy
- Inaugural Governor, Director and Trustee of UNDA
- Chancellor Emeritus UNDA
- Emeritus Consultant Physician Sir Charles Gardner Hospital
- Past Chairman of the National Governing Board of St John of God (SJOG) Healthcare
- Past Chairman of SJOG Foundation: responsible for
 - o Public appeal for the Community Hospice, SJOG Hospital Murdoch
 - o Public appeal for the Bendat Family Comprehensive Cancer Centre at SJOG Hospital Subiaco, incorporating specifically designed palliative care facilities
- Past Director of Sisters of Charity Health Service

I submit in my capacity as a registered Medical Practitioner concerned about the radical change in the practice of medicine which will occur following any legislation dealing with Physician Assisted Dying. I ask leave to appear before the Committee to present my case.

Professor Michael Francis Quinlan LLD, MBBS, MD, FRACP

In the previous debate about Physician Assisted Dying (PAD) legislation in Western Australia (WA), I signed a document to all Members of Parliament on behalf of the Catholic Doctors Association. I still stand by that document. On this occasion, I submit a statement in my own capacity, whilst noting that I am not a Palliative Care Physician.

My submission will address two issues: Conflict of Interest and Conscience

I am a Consultant General Physician and I have been practicing medicine for 55 years. I have been involved in the care of thousands of patients with a wide variety of diseases. This has included a significant number of patients with terminal diseases. My involvement in the care of the dying has been very personal. As a consequence, this has impelled me to be involved in:

1. The education of medical students and young graduates;
2. Heading the Public Appeal to build the Hospice at SJOG Hospital Murdoch;
3. Heading the Public Appeal to raise the capital funds to build the Bendat Comprehensive Cancer Care Centre at the SJOG Hospital Subiaco. This Centre incorporates a specially designed Palliative Care component; and
4. Including Palliative Care experience in the curriculum for the School of Medicine at UNDA Fremantle

From my experience, I remain totally opposed to any PAD legislation in WA.

Addressing the Committee's first Term of Reference, namely 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 experience chronic and / or terminal illnesses, including the role of palliative care.

Over the decades, I have seen many changes occur in the care of the dying, usually for the good. These changesⁱ include the provision of:

1. Hospices;
2. Home Palliative Care, in conjunction with the above;
3. Better involvement of the public and private sectors;
4. More Palliative Care doctors and nurses;
5. Inclusion of Palliative Care instruction and experience for medical and nursing students;
6. The inclusion of the Australian Chapter of Palliative Medicine within the Royal Australasian College of Physicians in 1999. This happened during my term as a Member of the Council of the College;
7. Change in professional and community attitudes towards Palliative Care; and
8. Recognition of Palliative Care by the governments of Australia and New Zealand.

The building of the Hospice at SJOG Hospital Murdoch came about because

1. A major new general hospital opened in 1994;
2. The Public Hospice at Mount Henry Hospital was to close, leaving no services South of the River;
3. The Sisters at St John of God had provided expert compassionate care to the sick and dying in WA since their arrival in 1895;
4. It was an opportunity to construct a freestanding hospice on the site of a major hospital – the ideal circumstance;
5. There were close linkages with the Silver Chain Domicillary Palliative Care Service; and
6. Public support was present, whereby the target sum for the Public Appeal was exceeded.

Since that time SJOG Health Care provides Palliative Care in six institutions across Australia. The point to be made repeatedly is:

Palliative Care must be of high quality and adequately funded.ⁱⁱ

To legislate for PAD immediately raises the issues of:

1. Conflict of Interest

All Boards of Companies, Institutes and Not-for-Profit Organisations with which I have been involved take very seriously the matter of any Conflict of Interest.

The Registration of a Medical Degree in Australia gives the Graduate the Licence to Cure or try to cure the disease and care for the sick. If, in future, legislation allows Physicians to participate directly or indirectly in Assisted Dying, it will add to the Licence to Cure the Licence to Kill. Thus is created the Ultimate and Fatal Conflict of Interest.

I contend that this Conflict of Interest will:

- irrevocably change the doctor-patient relationship;
- erode the quality of Palliative Care;
- compromise the professional standards of doctors;
- begin the journey of inclusion of non-terminal illnesses; and
- commodify dying and death.

Addressing Term of Reference Two, all of the above have occurred in overseas jurisdictions that have already passed legislation. For example:

In Canada, the 2016 legislationⁱⁱⁱ also licenses Nurse Practitioners to kill. Thus, two noble professions are compromised. Additionally, in Canada, there is a 10-day reflection period before the service is provided, BUT, if death is fast approaching, an exception can be made!^{iv}

In Switzerland, assisted suicide has been legal for decades. In 2010, over 60 (possibly more than 100) cremation urns were found in Lake Zurich. These bore the logo of the Zurich Nordheim Crematorium, which is used by Dignitas the Swiss non-profit organisation for assisted suicide.^{v vi}

In Belgium, Dr Patrick Wyffels, a general practitioner, performs euthanasia eight to ten times a year. In the days before and after the procedure, he finds it difficult to sleep, saying:

“You spend seven years studying to be a doctor, and all they do is teach how to keep people well – and then you do the opposite. I am afraid of the power that I have at that moment.”

The laws in Belgium, the Netherlands^{vii} and Luxemburg have been progressively amended^{viii} to include

- mental illness, particularly severe depression
- so called competent minors under the age of 18
- those who are “tired of life”^{ix}

2. Conscience

A simple, but not simplistic, definition of conscience is “to know what is right from what is wrong”. Conscience is partly innate, and it is developed and refined by learning and life experience.

- Everyone’s actions are, to a lesser or larger degree, directed by conscience.
- This is so in the practice of medicine, particularly in the care of the dying, for example
 - o The decision to give a particular drug to alleviate distress and the determination of that dose comes down to conscience. The dividing line between enough and too much is often fine. If that line is crossed or blurred wittingly, then palliation may, indeed, become euthanasia.

- Legislation to assist dying or cause death will inevitably result in the easy crossing of that line. Where then does that place the doctor-patient relationship; that trust which the patient has in the doctor exercise the duty of care?
- The practice of medicine is difficult enough without creating a moral morass which will emanate from legislation to assist dying. I suspect that Dr Wyffel's statement above suggests that his conscience is troubled.

In addition to the above two issues raised, I submit two personal experiences to further illustrate:

Account One

I was contacted by a General Practitioner who wanted me to look after a patient of his. I arranged her admission to SJOG Subiaco. That evening, shortly after her admission, I entered her room on my own. She was very distressed and, although wearing an oxygen mask, she was breathless as a result of severe heart failure. She grabbed my arm as soon as I introduced myself and said,

“Doctor, just give me a needle and let me go. No one will know except you and me”.

I responded,

“You know I can't do that. But what I can do is make you feel a lot better.”

Her heart failure was treated and by the next morning she was much less breathless and consequently much less anxious when I saw her. Again, I was on my own. She grabbed my arm again and said,

“I am glad you didn't give me that needle.”

This experience highlights several issues:

- The effect of distressing symptoms on the patient's psyche. This is what I call “illness behaviour”. Not only is that important for doctors to understand, but equally, if not more importantly, for nurses to understand as they spend more time with the sick.
- The importance of addressing and treating such symptoms – in this case severe breathlessness – not pain or nausea, two of the other major symptoms which most distress patients.
- Apart from alleviating physical distress, quality Palliative Care also seeks to address mental, emotional and spiritual distress in appropriate ways.
- People change their minds; underscoring the fact that “living wills” and “advanced directives” are not necessarily cast in stone. This highlights the importance, if possible, of a trusted family member or friend to be informed of the individual person's wishes.

Account Two

In 2000 my brother Tim Quinlan, a trained clinical psychologist and a Jesuit priest, was diagnosed with an incurable primary brain tumour. For some months, the rapidity of his decline in health was slow and he lived with his Jesuit community in Claremont. There came a time when his fellow Jesuits found his care more demanding. His Superior asked about a ‘respite’ of several weeks in the

This was organised and he was able to walk in without assistance, alert and fully aware of what was happening. The next day I went to see him and found him to be in bed and very drowsy. I noted that he had a morphine pump inserted subcutaneously. I was horrified and could see he would die within days if this protocol continued.

I notified his Superior and arranged for him to be transferred to SJOG Subiaco under the care of a physician. He lived for another six months during which time he had excellent care and he died peacefully with his family present. But it was not just a passive 6 months. For much of it, he lived out what I consider to be his

last and greatest pastoral act, not only consoling us his family, but a large sway of friends locally, interstate and from overseas.

This experience highlights several issues

- There are varying standards of Palliative Care from the excellent through to the poor. What I witnessed could be described as witting or unwitting euthanasia by stealth.
- Consequently, Palliative Care must be of a consistent high quality, as well as professional, compassionate and well-funded. As mentioned earlier, much has changed for the better including the provision of palliative Care in the Public Health system. In 1998, when I was negotiating the details of the support with the Department of Health for non-insured patients to be admitted to the Murdoch Hospice, a report was commissioned by the Department to look at such practicalities including the financial support required. The report recommended a daily bed subsidy which was just over half that provided by the Commonwealth Government for the patients in the Hollywood Hospital Palliative Care facility. The report also recommended that to contain costs as much of the care that could be given be given by dedicated volunteers. This situation has now thankfully changed since the 1990s.

ⁱ Caivus, Will., A Short History of Palliative Medicine in Australia, *Palliative Care and Cancer*, March 2007, Vol 31 Issue 1.

ⁱⁱ Kelly, Paul., Proper End of Life Care would avoid this Social Experiment, *The Australian*, 14-15 October, 2017

ⁱⁱⁱ Medical Assistance in Dying (MAiD) Legislation (Canada)

^{iv} Trachtenberg, Aaron. J. MD DPhil., & Manns, Braden. MD MSc., Cost Analysis of Medical Assistance in Dying in Canada, *Canadian Medical Association Journal*, 2017 Jan 23, 189 (3)

^v 300 urns with human ashes found dumped in Lake Zurich near Dignitas clinic, *The Telegraph*, April 27, 2010.

^{vi} Ban on human ash disposal reinforced, *The Telegraph*, June 14, 2017

^{vii} Greenwoud, Johanna H. MD., et al., Clinical problems with the Performance of Euthanasia and Physician Assisted Suicide in the Netherlands, *New England Journal of Medicine*, 2000: 342, 551-556

^{viii} Kelly, Paul., Legalise Euthanasia and Compassionate Society dies too, *The Australian*, October 1, 2016

^{ix} Aviv, Rachel., The Death Treatment, *The New Yorker*, June 22, 2015

^x Kenny, Mark., Don't do it: Paul Keating in 11th hour bid to stop euthanasia laws, *The Sydney Morning Herald*, October 19, 2017