

**Submission to: Joint Select Committee on End of Life Choices**

EOLC Sub 493  
Rec'd 22/10/2017

Attention: Principal Research Officer  
Joint Select Committee on End of Life Choices.  
Legislative assembly Parliament House PERTH WA 6000

22 October 2017

Re: End of Life Choices

The relationship between patient and doctor has been built on TRUST that the physician will carry out treatment to preserve the life of the patient.

Doctors used to swear by the Hippocratic Oath that has guided doctors for over 2000 years, which states "I will use treatment to help the sick according to my ability and judgement, but never with a view to injury and wrong doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course."

Once the state sanctions the taking of life by a physician that TRUST is forever broken.

Using the medical knowledge and technology of today and applying best palliative care practice there is no need for physician assisted suicide.

I fully support the Australian Medical Association Ltd Position Statement of 2016 on Euthanasia and Physician Assisted Suicide (attached) detailing the appropriate standard for good quality end of life care and the relief of pain and suffering.

The state should be improving the conditions for palliative care instead of embarking upon state sanctioned killing by a profession dedicated to saving life. Once that professional TRUST between doctor and patient has been tainted by euthanasia there will always be a cloud of suspicion and doubt over the administration of treatment.

Palliative care does not include artificial methods of extending life but caring for the patient and to let nature take its course in a pain free and caring environment. Modern medicine technology can be abused by intimidation and manipulation just as easily as the taking of a life.

Crossing the boundary of state sanctioned killing raises the prospect of potential abuse of the young, the elderly, the infirm and the mentally depressed. The overturning of state sanctioned killing within the criminal justice system was a considered a major advance in a civilised approach to criminal punishment. Even with the full extent of due process of the law there were irretrievable mistakes made by jurisdictions throughout the world.

Once the state sanctions physician assisted suicide our society will exhibit the same abuse of due process exemplified in other countries who have already embarked on authorised killing. Inevitably the opportunity for gain will bring out the worst of human nature regardless of the conditions imposed.

Modern medicine allows people to survive to old age whereby 100 years ago they would have passed away without the benefit of our technological advances in medicine and disease control. That does not give the state the authority to to dispose of people beyond their use by date.

I sincerely urge the committee to adopt the AMA position statement as a basis for defining end of life choices.

Yours Truly,  
Graeme Wishart

## Euthanasia and Physician Assisted Suicide

2016

### 1. Good quality end of life care and the relief of pain and suffering

1.1 Doctors (medical practitioners) have an ethical duty to care for dying patients so that death is allowed to occur in comfort and with dignity.

1.2 Doctors should understand that they have a responsibility to initiate and provide good quality end of life care which:

- strives to ensure that a dying patient is free from pain and suffering; and
- endeavours to uphold the patient's values, preferences and goals of care.

1.3 For most patients at the end of life, pain and other causes of suffering can be alleviated through the provision of good quality end of life care, including palliative care that focuses on symptom relief, the prevention of suffering and improvement of quality of life. There are some instances where it is difficult to achieve satisfactory relief of suffering.

1.4 All dying patients have the right to receive relief from pain and suffering, even where this may shorten their life.<sup>1</sup>

1.5 Access to timely, good quality end of life and palliative care can vary throughout Australia. As a society, we must ensure that no individual requests euthanasia or physician assisted suicide simply because they are unable to access this care.<sup>2</sup>

1.6 As a matter of the highest priority, governments should strive to improve end of life care for all Australians through:

- the adequate resourcing of palliative care services and advance care planning;
- the development of clear and nationally consistent legislation protecting doctors in providing good end of life care;<sup>1</sup> and
- increased development of, and adequate resourcing of, enhanced palliative care services, supporting general practitioners, other specialists, nursing staff and carers in providing end of life care to patients across Australia.

### 2. Patient requests for euthanasia and physician assisted suicide

2.1. A patient's request to deliberately hasten their death by providing either euthanasia or physician assisted suicide should be fully explored by their doctor. Such a request may be associated with conditions such as depression or other mental disorders, dementia, reduced decision-making capacity and/or poorly controlled clinical symptoms. Understanding and addressing the reasons for such a

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<sup>1</sup> The AMA supports nationally consistent legislation which holds that a doctor responsible for the treatment or care of a patient in the final phase of a terminal illness, or a person participating in the treatment or care of the patient under a medical practitioner's supervision, incurs no civil or criminal liability by administering or prescribing medical treatment with the intention of relieving pain or distress:

- a) with the consent of the patient or the patient's representative; and
  - b) in good faith and without negligence; and
  - c) in accordance with the proper professional standards;
- even though an incidental effect of the treatment may be to hasten the death of the patient.

A doctor responsible for the treatment or care of a patient in the final phase of a terminal illness, or a person participating in the treatment or care of the patient under the doctor's supervision, is under no duty to use, or to continue to use, life sustaining measures which are of no medical benefit in treating the patient if the effect of doing so would be merely to prolong life.

<sup>2</sup> Euthanasia is the act of deliberately ending the life of a patient for the purpose of ending intolerable pain and/or suffering. Physician assisted suicide is where the assistance of the doctor is intentionally directed at enabling an individual to end his or her own life.

request will allow the doctor to adjust the patient's clinical management accordingly or seek specialist assistance.

2.2 If a doctor acts in accordance with good medical practice, the following forms of management at the end of life **do not** constitute euthanasia or physician assisted suicide:

- not initiating life-prolonging measures;
- not continuing life-prolonging measures; or
- the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.

### **3. AMA position on euthanasia and physician assisted suicide**

3.1 The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of treatments that are of no medical benefit to a dying patient.

3.2 The AMA recognises there are divergent views within the medical profession and the broader community in relation to euthanasia and physician assisted suicide.

3.3 The AMA acknowledges that laws in relation to euthanasia and physician assisted suicide are ultimately a matter for society and government.

3.4 If governments decide that laws should be changed to allow for the practice of euthanasia and/or physician assisted suicide, the medical profession must be involved in the development of relevant legislation, regulations and guidelines which protect:

- all doctors acting within the law;
- vulnerable patients – such as those who may be coerced or be susceptible to undue influence, or those who may consider themselves to be a burden to their families, carers or society;
- patients and doctors who do not want to participate; and
- the functioning of the health system as a whole.

3.5 Any change to the laws in relation to euthanasia and/or physician assisted suicide must never compromise the provision and resourcing of end of life care and palliative care services.

3.6 Doctors are advised to always act within the law to help their patients achieve a dignified and comfortable death.

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