



24 October 2017

*Joint Select Committee on End of Life Choices  
Legislative Assembly  
Parliament House  
PERTH WA 6000*

*Dear Chair*

***Submission – Joint Select Committee, End of Life Choices***

*I write in my capacity as Moderator of the Presbyterian Church in Western Australia “(Church)”, and on behalf of the Members of the Church.*

*I attach for the review of your Joint Select Committee a Submission prepared by our Braemar Presbyterian Care Committee, a direct ministry of the Church, to your Committee’s review process.*

*Braemar Presbyterian Care (“Braemar”) provides services to the community and specifically to some 220 care recipients in a small number of residential aged care facilities in the Fremantle to Melville area of Perth. As well as exploring some strongly held Christian principles about end of life matters, the Submission focuses on some specific aspects of how a change in legislation to enable physician assisted suicide / assisted voluntary euthanasia might adversely impact on aged care services and perhaps a wider cross section of human/health services across this State.*

*The Submission has been prepared by the Chief Executive Officer of Braemar and has been approved by the Committee at its October 2017 meeting held last evening 23 October. It has also been agreed to by the General Assembly of the Church.*

*I apologise that this Submission is a day after the advertised closing date. We had received advice and approval from the Committee that this late Submission would be accepted due to the timing of our Committee meeting being Monday 23 October 2017.*

*Should you wish to pursue any aspects of this Submission please contact me as per the details that follow, or via Wayne L Belcher OAM, the Chief Executive of Braemar on 6279 3640, or via email at*

*Sincerely*

WA (Bill) MacRae  
Moderator, Presbyterian Church in Western Australia

23 October 2017

## **Report and Recommendations – Joint Select Committee on End of Life Choices**

This is a brief report with some recommendations.

Established in 1952, Braemar Presbyterian Care ("Braemar") has been offering aged care in Western Australia for 65 years. As a values based organisation, and a ministry of the Presbyterian Church in Western Australia, Braemar focuses on relationship centred care; empowering residents to live meaningful lives.

Wayne L Belcher OAM has been working back in the aged care sector since August 2016, and employed as Chief Executive Officer of Braemar since March 2017. We believe that Wayne's carefully crafted recommendations will have at least some support from both people of faith or no faith background.

Pain, suffering, and distress are existential. The desire to end one's own life is based on existential circumstances with perhaps the view that there is little hope for any future improvement in life's outlook. The majority Christian view still is that Christ offers hope for an end to all suffering, but that happens at the natural end of this life – not a life brought to early closure. The endurance of pain and suffering can seem intolerable, and the grasp of hope seemingly so far away. We must develop ways in which we can assist to bridge the perceived gap between the existential pain and future hope by how we manage our pain, symptoms, and suffering and sense of loss; yet contemporaneously offer support to others afflicted by such suffering, grief and loss.

The environment in which Braemar serves the Western Australian public is as an approved provider of (residential) aged care, where close to 90% of clients who come into our facilities for care will die in the facility in which they live out their final days, months or years. This is a complex environment in which to discuss "end of life" matters. The latest benchmarking in the residential aged care sector informs us that the average length of stay in a residential aged care facility is now just seventeen months. Increasingly, many of our incoming residents are entering into care with greater levels of frailty and several comorbidities. Those with the highest levels of frailty may in fact only be recipients of our care for fewer than six months – entirely in a palliative care like situation. Whilst this changing reality is to be expected as more and more people receive better home care services – a very positive outcome from a health care perspective, many folks really are entering into facilities seeking a palliative approach to care as very frail, mostly elderly people.

But whilst we engage with medical practitioners as part of our everyday role in care of residents, unlike hospitals, very few aged care providers in Western Australia employ, or otherwise formally contract with, medical practitioners around the care they provide to their patients. Most residents maintain a doctor-patient relationship with their existing general medical practitioner ("GP") when they enter an aged care facility.



Some others who move to a suburb too far for their previous GP to continue to visit are allocated to another visiting GP once they enter into care. Whilst the residential aged care provider may facilitate the visiting GPs by providing a treatment room or similar, the resident is the GP's own patient, for whom they claim Medicare rebates etc following visits and consultations with their patients. A visiting GP will hopefully add into progress medical notes held by the facility any commentary relevant to the ongoing care of the resident, but in every other way, the aged care facility has very little oversight and/or management of the GP's performance and clinical governance. The GP continues to have a confidential doctor-patient relationship with the residents they visit in our facilities.

An aged care provider is often caught in the middle of complex family dynamics where, if one or more family members are unhappy with the care regime prescribed by the GP, can often take out their angst on the provider. The notion of a GP acceding to a request for end of life options for a resident which might be contrary to family wishes, and certainly against any view that a provider holds, could present significant difficulties for the provider who does not otherwise have a relationship with the GP.

We do not support any introduction of physician assisted suicide. Nor do we support that being an outcome of care delivery to any resident in our facilities. Should physician assisted suicide be legislated in Western Australia, we seek relief from any proposed legislation to be supportive of wording such as the following:

*"Braemar Presbyterian Care ("Braemar") does not support the early termination of life through advanced health directives, advanced decisions, or similarly named instruments. Neither will Braemar knowingly support or be party to any overt action by a resident and/or family member, friend, or health professional or agency to deliver any medication that causes the death of a person earlier than the disease process would through natural causes and contemporary palliative care service provision. We are however supportive of a resident's right to refuse or withdraw treatment for reasons of personal choice due to futility or the potential harm that could occur to the resident. As an agency of the Presbyterian Church in Western Australia we value the sanctity of life and recognise it is not our right to choose to end life. Braemar is committed to providing excellent palliative care to our clients and a holistic palliative approach to care for all who choose to live in our facilities. If a resident were to choose physician assisted suicide (howsoever called) then we will use our best endeavour to relocate them, according to their wishes, to another organisation for the terminal phase of their care, but we will not knowingly participate in any process of physician assisted suicide / assisted voluntary euthanasia as may be approved from time to time by relevant legislation."*

I make the following statements and recommendations to the Joint Committee on behalf of Braemar, and the Presbyterian Church in Western Australia:

- (1) That the Joint Committee accepts that all human persons are precious and of intrinsic worth and that death is a normal and natural part of every human life;

- (2) Braemar Presbyterian Care (“We”) does not believe however that the practice of prolonging life with futile or burdensome treatment is morally acceptable, and that –
  - (i) Measures designed to artificially sustain life should not be adopted where it has been determined that there is no realistic prospect for a person to recover; and
  - (ii) Life support may be withdrawn once a person has reached the stage where there is no realistic prospect for them to recover;
- (3) We affirm however that the practice of intentionally ending life in order to alleviate suffering is morally unacceptable, and that it is not in the interest of society to allow life to be taken at will;
- (4) We believe that suicide for any reason or purpose should not be encouraged or condoned, and that active euthanasia and assisted suicide should remain illegal<sup>1</sup>;
- (5) We note that legalisation of physician assisted suicide (“PAS”) may encourage mistrust between residents and their carers, between residents and their families, between residents and their GP of choice, and between aged care providers and the representatives of residents whether those representatives are family members or the resident’s own health professional;
- (6) We are concerned that legalisation of PAS may result in creeping growth in the number of candidates for euthanasia and reduced funding for palliative and other end of life care;<sup>2</sup>
- (7) We are concerned that legalisation of PAS on the basis of one being able to choose to not live may reduce the right of a person who chooses to live. We must consider our societal responsibility to protect those whose quiet voice may be silenced amidst debate;<sup>3</sup>
- (8) We call on the Premier, the Leader of the Opposition, this Joint Select Committee and other Western Australian political leaders to oppose all initiatives to legalise euthanasia and/or PAS;
- (9) We also propose however that, should legalisation of PAS be promulgated, medical and other health professionals, and aged care and other human service providers, be entitled, without risk of, or penalty to their professional practice registration and/or licensing, and based on their own moral and conscience view, by withdrawing service from specific patients seeking active assisted suicide, and “ending-of-life” requests;

<sup>1</sup> Arthur J. Dyck, *Life's worth : the case against assisted suicide*, Critical issues in bioethics (William B. Eerdmans Pub. Co., 2002)

<sup>2</sup> BBC, *Alternatives at death's door* (31 December 2003) BBC.  
<[http://news.bbc.co.uk/2/hi/health/background\\_briefings/euthanasia/331273.stm](http://news.bbc.co.uk/2/hi/health/background_briefings/euthanasia/331273.stm)>

<sup>3</sup> Kenneth Klothen, 'Tinkering with the legal status quo on physician assisted suicide: a minimalist approach' (2013) 14 *Rutgers Journal of Law and Religion* 361



- (10) We strongly believe that the State has an obligation to promote the health and wellbeing of its citizens – especially those who are elderly, disabled or otherwise vulnerable to abuse;
- (11) We strongly believe that assisted suicide exercised with elderly and/or people with disabilities is tantamount to abuse at least based on the suppositions that pain and other symptoms cannot be adequately managed, and there is cost saving potential to the public purse by easing the way for these end of life choices to be carried out. These suppositions have no place in fact and the end of life outcome has no place in a caring society;
- (12) We believe that the four pillars of modern biomedical ethics being autonomy, beneficence, non-maleficence and justice for all are biased towards the sense of self autonomy which in turn is out of balance of the four working as a whole to the benefit of the broader community. We believe the move towards more self-autonomous choice and demand is not beneficial to our Western Australian society;
- (13) We believe that, should PAS, howsoever titled, be legalised in Western Australia, we may be legalising a principle that says when one feels that their pain and suffering is too great, they can request PAS to remove the pain and suffering;
- (14) We believe that right will cause people with disabilities, developmentally impaired people without their own voice, and frail elderly, to fear that they will have a “duty to die” forced upon them. This duty would reinforce “archaic views of disability” and a wider sense that elderly people “who are terminally ill have a duty to die and get out of the way”<sup>4</sup>;
- (15) We believe that some will want to explore the perverse incentive of health care financing of low cost PAS versus palliative care, and the possibility of driving the cost of health care down through such “opportunity”<sup>5</sup>;
- (16) Finally, whilst people chase this elusive right to die, not even the proposed legislative changes in other Australian jurisdictions provide for that right, because, albeit those others might be sympathetic, the qualification to be able to die with dignity rests with others, and not with the patient.
- (17) We call on the Western Australian State Government to commission research into alternatives to euthanasia and PAS and how all Australian Governments can actually restore funding mechanisms to aged care providers so that better palliative models of care can be offered to all care recipients to enjoy a high quality of life in care, met with funding equity and capacity to deliver such care; and

<sup>4</sup> Edward J. Larson and Darrel W. Amundsen, *A Different Death: Euthanasia & the Christian Tradition* (Intervarsity Press, 1998), 172

<sup>5</sup> Ezekiel J. Emanuel and Margaret P. Battin, *What Are the Potential Cost Savings from Legalizing Physician-Assisted Suicide?* New England Journal of Medicine.  
<<http://www.nejm.org/doi/full/10.1056/NEJM199807163390306>>

- (18) We call on Federal, State and Territory Governments and the corporate sector to encourage alternatives to suicide and euthanasia and to provide increased funding for pain management, palliative care, suicide prevention, and life formative counselling.

Wayne L Belcher OAM  
Chief Executive

WLB:WLB [1710]

## References

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