SUBMISSION to the joint Select Committee on End of Life Choices,enquiring into the need for laws in Western Australia to allow citizens to make informed choices regarding their own end of life choices.

Submitted by P. Mahoney
Catholic Mental Health Network

General Position

I have supported people with Mental Illness and Disabilities for almost 30 years through my family circumstances and association with Emmanuel Centre a self help Agency
I am therefore well acquainted with the many life challenges affecting people in this situation not the least of which in cases of mental illness in particular are feelings of hopelessness which can in times of severe illness impact their thinking. Invariably with proper care these episodes pass and life can be lived fully. There is suffering in this situation but the answer is true compassion and life affirming support from society. Some suggest that death is better.I disagree. The first road encourages everyone to work towards acceptance, healing and valuing life while the second is negative,qualified,utilitarian and questions the worthiness of some lives.

Reasoning

There are two principles that our Society and the Medical profession have always upheld:

1. The absolute prohibition of one person intentionally killing another.
2. In the practise of medicine one should do no harm. It is self evident that this should preclude any physician from actively engaging in killing a patient.

This position is supported by professional bodies such as the Australian Medical Association and the American College of Physicians
As helpers to those with Psychiatric issues we are acutely aware of the potential for abuse should the State ever sanction the killing of any person.
If the State decides that the individual has full autonomy in ending life then the medical profession instead of being a healer becomes merely an instrument in the hands of the patient and significant others.
Palliative care properly understood and practised is the antidote. Some do not accept this and quote special situations. It is well known that hard cases make for bad laws.

Addressing Term of Reference One: Choices at End of Life Management

Ethics, Definition and Implications

The Enquiry makes no reference to the ethical/moral issues involved . It appears to be a purely utilitarian approach.
The definition of chronic and/terminal can be widely interpreted. This is critical in understanding the implications for those with Disability and Psychiatric issues as they can live their entire lives in what some would regard as a chronic or even terminal condition.

Disability and Mental Health legislation exist to protect and enhance the life experience of people which is not compatible with physician assisted suicide. See articles by Disability Advocates in the Guardian (20/9/17) Margaret Somerville:(27/9/17) Craig Wallace and . Jonathon van Maren,(Life Site News.com).These resources outlines the vulnerability of people in this situation.
A further consideration is the general belief that physician assisted suicide is without trauma. The 2016 Position Statement from St. Vincent Health Australia states in part

> " Death and dying, like birth,can't be scripted- no law or medication can achieve this, including assisted suicide. Nor is assisted suicide a simple procedure with 100% effectiveness. A patient will likely be required to take a chain of increasingly strong medicines including a drug to prevent vomiting; a drug to reduce anxiety; and then a lethal drug to stop their breathing. Evidence from overseas shows complications can include: seizures; failure to induce coma; and a longer than anticipated death,requiring a physician to euthanize the patient"

Current Practises including Palliative Care

Current practise is based on the **Hippocratic Oath** which dictates that " **above all do no harm "** and is foundational to the faith patients largely place in the profession. If physician assisted suicide is permitted then the dynamic between society and the profession will forever change from one of healing and relief of distress to one of death dealing. The implications for people with mental illness who live with the fear of suicide cannot be minimised.
Palliative Care has made much progress but it is not well understood even in the medical profession and even less so in the community. Consequently it is under promoted and under funded. **See Position Statement by Palliative Care Australia entitled Euthanasia and Physician Assisted Suicide.(palliativecare.org.au)**

Addressing Term of Reference Two and Three: Legislation, Reports and Materials

When legislative change is proposed proponents always point to safeguards as a way of avoiding abuses. Yet there is considerable evidence which indicates not only abuse but gradual extension of eligibility.

> David Mulino MLC (minority report Victorian End of Life Choices enquiry) says clearly that (despite majority report concluding that safeguards work) "a balanced reading of the evidence would lead one to conclude that such an unequivocal statement is not true"
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> Simon O'Connor , Chair New Zealand Parliamentary select committee into assisted suicide explains the decision not to support the proposal by saying "once assisted suicide and euthanasia is enacted there is the slow but predictable broadening of access. It quickly ceases to be terminal illness and becomes permissable for any form of pain".
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> The American College of Physicians Position Paper –Ethics and the legalization of Physician Assisted Suicide provides a compelling case for why it does not support

assisted suicide.(annals.org/article/2654458)

Research into legislation, reports and other resources should not only focus on what currently exists and what practises apply but look deeply into the reasons why in so many jurisdictions attempts to introduce assisted suicide laws have failed: In the United States for example I understand 23 States have rejected such legislation. Look also at the U.K.

Addressing Term of Reference Four: Role of Advanced Health Directives Enduring Power Of Attorney and Enduring Power of Guardianship

In the case of people with psychiatric illness the role of such instruments raises many questions.

Psychiatric evaluation is given as one of the safeguards in Physician Assisted Suicide but at the same time the person could be regarded as a candidate for PAS because of the illness. Suicide ideation is common in mental illness yet a person competently treated and supported can live a full and productive life. So the timing of using these instruments is critical. In the case of Guardianship the person is likely to be more vulnerable.

A person with mental illness can be involuntarily admitted to a psychiatric institution and so is always at risk of someone else making life decisions for them; this is bad enough when the medical profession is charged with doing no harm but would be intolerable with or without these instruments should Physician Assisted Suicide be legalised.

Conclusion

There can be no middle ground in this matter. Life is sacred or it is not.

Physicians should remain faithful to their Hippocratic Oath to do no harm.

Containment once the line has been crossed is impossible as has been shown in many cases.

Those who live with mental illness are amongst the most vulnerable of people and should be able to live their lives knowing that Society will at all times see them as worthy of life.

My own family experience informs my view on Physician Assisted suicide.

My wife had Parkinsons Disease for 25 years. I not only supported her on the journey but nursed her at home for a few years before she had to go into care because of her medical needs. She died peacefully with good nursing and Palliative Care surrounded by her loved ones.

Within 2 years of my wife's passing my second daughter died at home from cancer of the mouth; she was supported by Palliative Care and two of her friends who were nurses and as a result passed away peacefully surrounded by her family.

P. Mahoney
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