Euthanasia in Western Australia
2019 Australian Catholic Youth Festival

Speech

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Background

On 23 August 2017, the Parliament of Western Australia established a Joint Select Committee of the Legislative Assembly and Legislative Council to inquire and report on the need for laws in Western Australia to allow citizens to make informed decisions regarding their own end of life choices. The Inquiry received nearly 700 submissions, about 65 per cent of which opposed introducing laws to permit physician-assisted suicide or euthanasia.

The Committee handed its Report to Parliament on 23 August 2018. Of the 24 Recommendations, eighteen were concerned with statutory instruments for decision making at end-of-life and with challenges in improving access to specialist palliative care. Six recommendations propose introduction of laws to permit 'voluntary assisted dying'.

The Government established an Expert Panel chaired by former WA Governor Malcolm McCusker QC to advise it on framing legislation to enable euthanasia and assisted dying. The Panel issued a Discussion Paper on 19 March, with feedback from the public submitted by 24 May 2019. The bill was then finalised in draft form, and tabled in the Legislative Assembly (which is the Lower House of Parliament in WA) on the 6 August.

As we speak today, the Bill currently sits in the Upper House, and committee of the whole House (where each clause in the bill is examined in detail) has been seeking to complete this process this last week. The government hopes that once the proposed amendments to the Bill have been considered and decided, the Bill will be ready to be passed back to the Legislative Assembly for voting on the amendments. They hope that it will be passed into law by Christmas, otherwise this will have to be deferred until February next year, as parliament will have entered its summer recess.

What are euthanasia and 'assisted dying' – some considerations.

In practice, euthanasia is defined as any action or omission which of itself and by intention causes death, with the aim of ending suffering. It has been known by other names, such as 'easy death' and 'mercy killing'. 'Euthanasia' requires one person to take an action which causes another person ('the patient') to die. The death of the person is the intended outcome of the action taken. 'Voluntary euthanasia' is said to occur when this happens at the patient's request. Otherwise it is 'involuntary euthanasia', or simple killing.

One point of contention in this current debate is whether Parliament should define 'voluntary euthanasia' so as to differentiate it from 'wilful murder'.

‘Assisted dying’ covers a range of situations in which one person (often a doctor) provides material help to the patient so that the patient can take his/her own life – so it is also sometimes called ‘assisted suicide’. ‘Material help’ from a doctor might include writing a prescription for lethal drugs, providing these drugs, and even teaching the patient how to use these drugs to end their own life. Currently it is unlawful to assist a person to commit suicide. Another point of contention in the current debate is whether Parliament should make it lawful to assist suicide in some instances.

The Catholic View

Life is a gift, to be protected and promoted, especially for those least able to care for themselves. To people of faith, life is the fundamental gift for a person, in fact, the gift of God’s love.
Human life is also eternal: death and dying are normal human moments in life marking the transition from mortal to eternal life. The experience of suffering and pain is also part of the human condition. Medical science has made great progress in Western societies, to the extent that the average life span of men and women has increased since the early twentieth century, perhaps by another twenty years. However, this has meant that there are many more types of disease appearing in the population because we live longer. Still, medicine is finding more cures and life is being prolonged.

Along with this progress in medical science and new treatments, our societies are becoming more secularised and materialistic, so people are finding it more difficult to find meaning in old age and death. They question whether or not they have the right to eradicate suffering by resorting to euthanasia.

Personal stories and experiences of witnessing pain in loved ones who are dying or have chronic diseases, lead some to believe that they should be able to ask for death for themselves or for others.

What is the appropriate response of the person of faith when faced with suffering?
Physical suffering is part of the human condition. It is inescapable as we experience it from infancy through all the stages of life. In fact, suffering is one of our teachers, as it rather usefully gives us a warning. We learn from the experiences of pain what to avoid, how to be prudent and safe. Suffering causes us anguish and when it becomes severe we naturally seek ways to remove it at any cost.

Suffering, pain and dying can be very lonely experiences. Medical care is now able to provide better management of pain. Good palliative care, if made available, will bring relief and increased comfort. Added to good palliative care, the dying person needs to be surrounded by the people closest to them to be reassured, accompanied and loved. This adds an essential human element: to share in their journey of acceptance of death and preparing for the transition from earthly life to eternal life.

Therefore on one hand we must never deliberately and directly take anyone’s life, but on the other hand, neither are we obliged to keep people alive indefinitely.
When death approaches it can be perfectly reasonable to allow nature to take its course, neither delaying nor directly causing death to occur.

Any person who is offered medical treatment can ethically refuse it, or ask it to be withdrawn if, in that person’s view, the treatment would be either (a) not reasonably therapeutically beneficial, or

(b) unreasonably burdensome. A person is entitled to make advanced end-of-life directives on treatments or care they want when they become incapacitated in their final illness. Those entering one of our aged care homes are asked to complete the declaration indicating the kind of treatment they would want or whether they would prefer to allow the disease to take its course and normal care for the person is not interrupted.

> *[T]he decision not to instigate a form of treatment (e.g. some forms of resuscitation) would be justified if the burden of treatment would be disproportionate to its expected therapeutic benefits or if it would involve an unreasonable burden on the patient (in particular on a frail, elderly or dying patient). (Code, 5.11)*
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> *The burdens of treatment to be properly taken into account may include pain, discomfort, loss of lucidity, breathlessness, extreme agitation, alienation, repugnance and cost to the patient. In some cases, the burdens of treatment may also include excessive demands on family, carers or healthcare resources. (Code, 1.14)*

This applies even if the treatment is necessary to sustain life. We are under no obligation to prolong life at all cost, but neither must we deliberately and directly take any person's life.

Risks of Assisted Suicide and Euthanasia [ASE]

One of the myths of Euthanasia is that it guarantees a 'peaceful death', and is therefore compassionate. The following information is part of the reality of Euthanasia across the globe.

Wrongful death: Many years ago, the WA Government stopped using the death penalty for fear of causing 'wrongful death', which is what happens when a mistake of some kind leads to the death of an innocent person despite process through courts, appeals etc. ASE sets up the probability of wrongful deaths, (a) with responsibility borne by doctors alone, and (b) without as many checks and balances

Faulty process: Anaesthetics: even in the 'best' circumstances there is a high complication rate: difficulty in swallowing medication (<9%), vomiting (<10%), death takes a long time (up to seven days <4%), failure to induce coma and the patient wakes up (<1.3%).[1] The assumption that death will be gentle is not supported by the facts in many cases.

Suicide confusion: Eight people in Australia die each day by suicide, and we invest heavily in major suicide prevention and counselling programs like *Beyond Blue* and *LifeLine*. ASE will introduce an acceptable kind of suicide – 'white homicide' – that is approved and even funded by the State. How will this affect suicide rates in Australia? In the US State of Oregon the suicide rate in 2012 was 42% above the national average.[2]

Bracket creep: Any 'safeguard' one government introduces can be relaxed by another government; and advocates already want much more liberal access to ASE. 68 'safeguards' in the Vic legislation mean nothing in the long term

Threat to maintain scope of practice: Catholic and other providers of health care inevitably come under pressure to conform and provide ASE, even though State laws supposedly provide a right of conscientious objection. Government wants people to have the right to access ASE if they choose, but people also have a right to be treated in public facilities where they know ASE will not be offered.

[1] Sinmyee S, et al. Legal and ethical implications of defining an optimum means of achieving unconsciousness in assisted dying. *Anesthesia* 2019. doi:10.1111/anae.14532

[2] [2] Shen and Millet (2015), *Suicides in Oregon: Trends and Associated Factors 2003-2012*, Oregon

Change in doctor-patient relationship: Many doctors who start out offering ASE change their minds because of its psychological impact on them; it is natural that many patients worry about whether their doctor is offering the best care, or simply taking the short path to assisted dying.
Elder abuse: Pressure on older people to end life, so that children can inherit. This already exists, and ASE will provide another pathway to inheritance. Difficulty in knowing who is making free and willing request for ASE and who is not. See *The Mother Situation* on www.careforlife.net.au
Further marginalisation of the vulnerable: Advocates for the disabled and vulnerable are concerned that creating access to ASE will further marginalise them – they already feel unwanted.
Lack of focus on access to specialist palliative care: at Nov 2018 WA had only 15 FTE public and private Palliative Care specialists in the State (v 150 psychiatrists) or 0.57FTE PC specialists per 100,000 people, the lowest ratio of any State. Public PC cost $43.5 million. To achieve the national average (1.0FTE per 100,000) would cost an extra $32m p.a. ($76m total); to achieve the Palliative Care Australia recommended ratio of 2.0FTE per 100,000 would cost $151m p.a. in total.
So – what have we done in the face of this?

- Issued public statement encouraging politicians and members of the public to look for another way – particularly focusing on the funding and development of expert palliative acre across Western Australia.

- Started an organisation called Care for Life, which operates from the L. J. Goody Bioethics Centre in Mt. Hawthorn. The Care for Life team have been responsible for coordinating the writing of letters from members of the public to MPs, encouraging them to vote against the legislation of euthanasia. Across the Care for Life campaign, many thousands of letters have been written to members of the Lower and Upper Houses. In addition, the Care for Life team have been working alongside the AMA(WA), and numerous State and Federal politicians to direct the campaign strategically towards a more compassionate and life-affirming end.

- We continue to invest heavily in our hospitals and care facilities, and have taken steps to ensure that all Catholic facilities remain 'VAD free' spaces in this law passes. No matter the legislation, our ethic of care remains the same, and patients and their families can come to a Catholic healthcare of aged care facility with the knowledge and comfort that VAD will not be raised, encouraged, suggested, or otherwise enabled. Our facilities are founded on the idea that life is a gift from God, and that we are the stewards of it from conception to a natural death.

- We have coordinated an interfaith service, gathering many of the major religious traditions represented across Perth at St. Mary's Cathedral on Sunday the 29th of October. It was a celebration of life in all its glory and its challenges, and an opportunity to demonstrate that on core issues of life and human dignity, the major religious traditions are of like mind, and supportive of one another.

The Good Samaritan

When we look to the Gospels for inspiration and to discover the way to live the Christian life, the parables of Jesus often provide what we are looking for, and as we consider the question of euthanasia, the parable of the Good Samaritan seems most instructive.
A man on a short trip to Jericho is ambushed, beaten and robbed, and left for dead, the beating had been so severe. Of the passers-by, only the Samaritan, a despised foreigner, stopped to help the man. In fact he interrupted his own journey to help, for he spent that day and all night tending his wounds and comforting the man.

Jesus told this story to answer a question designed to test him. He was asked, “And who is my neighbour?”

Jesus turns the question back onto the teacher. “Who made himself a neighbour to the suffering man?”

“The one who had mercy on him.”

“Go then and do the same.”

It is as if Jesus says, “Do not try to figure out who is my neighbour; listen instead to the call in the heart, and become a neighbour. Be close to any brother or sister in need.”

Loving or showing mercy does not just mean being moved by another person’s distress.
Notice that the Samaritan stopped in that dangerous place; he paid for all the man’s expenses; and promised to pay everything else that it took to care for and comfort the man.

The Samaritan’s love was unconditional and he refused to be put off by risks to himself. Above everything else, he is focussed on taking care of the wounded man.

Euthanasia is not the answer to the diagnosis of a terminal illness. The fear of pain and suffering is real, but the anguish that is felt by the person who is dying is much deeper. The deeper need is to be helped and loved.

“What a sick person needs, besides medical care, is love, the human and supernatural warmth with which the sick person can and ought to be surrounded by all those close to him or her, parents and children, doctors and nurses.” Declaration on Euthanasia, Sacred Congregation for the Doctrine of the Faith, Rome, 1980