



LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON END OF LIFE CHOICES IN THE ACT

Ms Bec Cody MLA (Chair), Mrs Vicki Dunne MLA (Deputy Chair), Ms Tara Cheyne MLA,
Mrs Elizabeth Kikkert MLA, Ms Caroline Le Couteur MLA.

Submission Cover Sheet

End of Life Choices in the ACT

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Submission to the Inquiry into End of Life Choices in the ACT

Dr R. M Edwards

[REDACTED]

Deakin. ACT 2600

Email: [REDACTED]

Phone: 02 [REDACTED]

Inquiry into End of Life Choices in the ACT

The terms of reference of this inquiry include 'community views on the desirability of voluntary assisted suicide' and 'risks to the community and individuals'.

Assisted suicide in this context means for medical professionals to provide the means for a person to take their own life, such as medication, while euthanasia is when a person actively and deliberately ends the life of a person in an end-of-life situation, such as administering a lethal injection. It is presumed in the current context that euthanasia follows the consent of the person, or those responsible for him or her, in order to alleviate intolerable suffering when a person has a terminal illness. However, the term can be used in contexts where consent and establishment of intolerable suffering are ambiguous.

While there is much emphasis in this discussion on the rights of the individual, little consideration seems to be given to the community dimension. While individual rights are extremely important, they are not the only factor. Civilization or life-in-society is necessarily a balance of individual good and the common good of the whole group. No individual is permitted to do exactly what s/he likes, or social life would be chaotic and other individuals would suffer. Many of our laws limit individual freedoms for the good of the whole community.

This principle is applicable to end of life issues. If assisted dying is legalised, it may benefit a few (usually relatively wealthy and well-informed people) but it weakens the basis of society and the value of people, thus threatening those who are more vulnerable those with dysfunctional family relationships, social disadvantage, elderly people lacking self-worth, or those with depression or other personal characteristics which lead them to need more support to lead fulfilling lives. To legalise assisted suicide or euthanasia is to define the value of a life by the social contribution made by a person and/or their quality of life. It establishes a precedent that in our society, people who are unproductive or unhappy do not have value and are better put out of their misery.

Many in our society disagree with such a philosophy. Moreover, there are many examples of disabled, depressed or suffering people who themselves have articulated that they value their lives. Often the extreme circumstances that lead to suicidal wishes change, perhaps through medical advances, pain reduction treatments or emotional support. However, a euthanized person has no opportunity for such a second chance.

Research shows that the main reasons people request assisted dying are not unrelieved pain, but fear of loss of dignity, fear they are a burden on others and loneliness. All of these can be addressed in a caring and compassionate society.

While end-of-life bills stress that they require stringent conditions for legally assisted suicide, both the reliability and the cost of policing these provisions are negative. It would be better that money be spent on providing a social environment, including adequate financial services, to support people in hard circumstances, to protect these vulnerable people and to provide a positive social culture where every person is valued and resources are allocated to meet their needs.

I am regularly surprised by the failure of the public discourse to make connections between different social phenomena. In the very era when widespread domestic violence and elder abuse is highlighted, even with posters on major Canberra roads, we have governments seeking to introduce legislation which undermines the established principle of the supreme value of life. People who abuse their elderly relatives, make money out of poor aged care facilities or are violent towards their partners and children are hardly to be trusted with disinterested decisions about those they are responsible for. And statistics generally note that large numbers of such abusive people are hidden, appearing pleasant to outsiders.

Legalising assisted suicide encourages them on two levels: it endorses that unselfish, altruistic behaviour is not valued in life-and-death situations and it provides a practical opportunity to exploit the vulnerable. It appears to me incredibly naïve to believe that legalising assisted dying will not be open to abuse, no matter how stringent the laws may be in purportedly providing safeguards or how many assertions there are that the ill person makes their own choice. Choices are made in a context of other relationships, which influence a person's thinking and self-evaluation.

Focusing one dimensionally on any individual's personal choices loses track of the much wider social implications, including the changed relationship with medical professionals. What is lost in this debate is the philosophic principle going back to classical times that a doctor's first responsibility is to preserve life.

If this principle were taken seriously, the focus would be on good palliative care, counselling for carers and spiritual and psychological support for people facing distressing mortality. However, the cheaper option, both financially and in terms of emotional demands, is for people to opt for assisted dying, perhaps encouraged by their relatives, perhaps by their own sense of worthlessness or the supposed indignity of the universal human experience of suffering and occasionally by extreme pain. Those rare instances where pain cannot be ameliorated are an area for medical research, not for giving up and getting rid of people. The example of Stephen Hawking shows that even extremely disabled people have worth and value and can contribute towards their community, not least in encouraging compassion and the affirmation of diversity, instead of populist conformity to unrealistic images of beautiful, successful, happy people.

While other countries or jurisdictions may have moved in this direction, this is no reason for the ACT to do so. Rather, with a smaller population and area, it is ideally placed to put resources into providing the very best social services, medical treatment and palliative care.

Evidence from overseas, especially from the Netherlands and Belgium, which show an increasing devaluing of human life, should not be dismissed lightly. The change in values which assisted dying encourages has much greater ramifications than ending the lives of a few suffering people. It makes a statement to the whole society of what makes a worthwhile life, and logically leads to lack of care for those who do not fit the criteria. We talk much about self-esteem, but do little to help those whose life circumstances have lowered their sense of worth.

Many Australians still believe that every person is intrinsically of value and that doctors and health professionals should always focus on saving life, not ending it, regardless of the social or utilitarian value of their patients.

In asserting their primary duty of care, in Clause 1.6 of their position paper the AMA urges government resources to be focused on good palliative care. I believe, along with many other Australians, that this is the priority, not encouraging a devaluing of life, through knee-jerk reactions to the dramatic stories of a few individuals emotionally highlighted in the media.

The ACT legislative assembly, consistent with its support for enlightened social policy, should choose life, not death.

R. M. Edwards