



Note to Personal Assistant: this is for the individual member's consideration. The member holding the appropriate portfolio will also have received this letter.

17 June 2008.

Member of Legislative Council (letters individually addressed)
Parliament of Victoria

Dear Sir/Madam,

Medical Treatment (Physician Assisted Dying) Bill 2008.

The proposed bill to legalise Physician Assisted Dying, more commonly and appropriately called Physician Assisted Suicide (PAS), has far-reaching implications for the individual, the community, the doctor-patient relationship and the future of medicine – not just in Victoria but for the whole of Australia.

For the individual there inevitably comes the 'duty to die' – the pressure on the dying or incurable to ask for death even when they want to keep on living – to relieve emotional, physical or financial distress on relatives or carers.

The duty to die can also reflect a 'societal' obligation with pressure being felt by an elderly infirm person in an overcrowded, understaffed nursing home where there is an expectation that they will agree to a lethal dose of medicine because it is better for society.

Legalisation lends 'state' approval for PAS as a valid option for people – including the young – to consider what they would otherwise not consider. There is then a wider community attitudinal expectation that individuals will choose this option.

Women especially may request to die because they fear being a burden to their families, when what they really want is to hear that they are loved and wanted and valued to the natural end of their life.

Economic pressures will then have the effect of failing to maintain or even reducing palliative care services in favour of the cheaper option of PAS.

For the doctor-patient relationship such legislation would create confusion – at the very least a perception by the patient of ambiguity in the role of the treating doctor and fear that the doctor's attitude might change somewhere along the line of care. Patients may justifiably conclude that doctors would be less enthusiastic in their care if they think the patient should be prepared to die and are supported in this view by society and the law.

For doctors, assisting someone to die flies in the face of time-honoured medical ethics. It is for very good reason that the Hippocratic Oath states that *I will give no deadly medicine to any one if asked.*

Although doctors have sympathy for those who are dying and who want to hasten the process, compassion means much more than simple acquiescence to patient demand. The option of very good palliative care means that relief from pain and distress is increasingly achievable and obtainable. Killing should never be seen as a solution for misery.

But it doesn't end there. The very thought of doctors determining – even by acquiescence – which lives are appropriately terminated and the ultimate implications of this for the impaired and disabled in our world is a terrifying thought.

Further, the push to extend the 'right to die' from those who are 'mentally competent' to those who are not and to have an agent respond on their behalf will be a logical follow-on. Then the 'benefits' can be extended to include children and newborn infants with a disability, as is happening in The Netherlands.

Inevitably the definitions of 'terminal' and 'intolerable' will also be pushed. Already the draft legislation includes 'existential' under 'intolerable'. This could then legitimise the desire to suicide, where living itself is considered intolerable, by a person not considered to be depressed. Depression of course can lead to a perception of intolerability but if recognised is very treatable.

Early cancers that are known to be 'incurable' and therefore 'terminal' e.g. mesothelioma, can be caught up in this scenario even though considerable quality time could be anticipated. In the draft legislation even palliative care is given the qualification that it must be 'acceptable to the sufferer'.

It is worth noting that in a 1999 review by Prof David Kissane (a palliative care specialist) of seven deaths in the NT during the time of legal euthanasia that pain was not a prominent clinical problem but 'fatigue, frailty, depression, and other symptoms contributed more to the suffering of patients.' He noted that there was a 'need to respond creatively to social isolation and to treat actively all symptoms with early and skilled palliative care.'

It is well known that many who wish to die change their minds when they receive good palliative care.

It is apparent that many from the euthanasia and PAS lobby will not be content with death just for terminal or incurable illness. They want to extend the time before death to a time of their choosing and to extend the definition of illness to include readily treatable diseases and existential suffering.

The proposed Victorian legislation supports an advancing culture of death, adding to the philosophy already apparent in our society and in our young people – *if things get too hard, I'll just kill myself.* In response all doctors and all Australians have an obligation to actively promote and honour a culture of life.

Dr Lachlan Dunjey MBBS FRACGP DObstRCOG General Practice (contact person)
33 Bunya St Dianella WA 6059 mob 0407 937 513
(signatories follow on original individually addressed letters)