

Dear Prof Ecclestone,

Thank you for the opportunity to provide a submission into the VAD (end of life choices) Bill 2020.

I note the terms of reference.

I note that it is only in the 2nd dot point of the last of the 5 terms of reference that the phrase "should the legislation passed into law" appears. This does rather suggest that we are being asked to contribute to a fait accompli and that this review is not really about whether this legislation should be implemented but rather how it should be implemented.

The risks and benefits of euthanasia/physician assisted suicide have been debated interminably over the years and I seem to have accumulated a dropbox folder with hundreds of items of correspondence, clinical papers and newspaper articles over the more than 20 years since the Tasmanian Parliamentary enquiry in 1998.

You may recall that the committee's findings at that time included:

1. Legalisation of voluntary euthanasia would pose a serious threat to the more vulnerable members of society and that the obligation of the state to protect all its members equally outweighed the individual's freedom to choose voluntary euthanasia.
2. The committee found that in the majority of cases, Palliative Care was able to provide optimum care for suffering patients.
3. The Committee recognised that in a small percentage of cases, Palliative Care was ineffective in relieving all pain, however whilst regrettable this is not sufficient cause to legalise voluntary euthanasia.

For your information and interest I have attached 3 items sampling my involvement with this debate over the years and have also included a brilliant historical perspective written by Ezekiel Emanuel which appeared in Annals of Internal Medicine in 1994.

This article is essential reading for anyone wishing to gain a historical perspective. The point is made in the conclusion that "it seems clear that the arguments for and against euthanasia have changed neither in form nor substance in almost 120 years".

So this begs the question... Why now in Tasmania?

In my opinion, this legislative proposal has been generated by a tidal wave of emotive and unverified accounts of poor end-of-life outcomes. There seems to be a pervasive notion that end of life care in Tasmania is really terrible and something drastic must be done now. The truth is, there are actually no statistics, hard facts or sound evidence to back up that proposition. None of these hard cases have been investigated by the appropriate statutory authorities such as the Tasmanian health complaints Commissioner or the Australian health practitioner regulation authority. The proponents of this bill have run an effective campaign which has unsettled the community and this has led to a political imperative to "do something".

The rational response to this would be a prospective study covering the entire State of Tasmania over a defined period such as 12 months to examine all reports of unsatisfactory end-of-life care or inadequate symptom control. At the end of this period, we would have a reasonable idea of how many of the 4500 or so deaths occurring annually in Tasmania were suboptimally managed and in what proportion of those that unsatisfactory outcome was due to failure of delivery of best available care and in how many it was due to symptoms that simply could not be managed even with the best available care.

That would then at least define the magnitude of the purported problem. Following that, it should be possible to make an objective, sober and rational decision as to how the situation may be improved.

That would be the scientific and rational approach but unfortunately that option does not seem to be included in your terms of reference.

So returning to your 2nd term of reference with its reference to "safeguards and protections for vulnerable people" I would make the point that the very best safeguard would be the exclusion of medical practitioners from the process. I am well aware that Prof John Burgess has written to you about this and I would refer you to his submission and overview of this critical topic.

I would also make the point that it is not only the patients who are vulnerable. Everyone associated with the active taking of a patient's life is vulnerable. Not only the doctor whom the current legislative draft charges with the awesome responsibility but also the other members of the healthcare team, the nurses, the ward clerks, the orderlies and everyone on staff, in the vicinity and indeed in the community.

Finally I have noted a change in the narrative recently, especially on reviewing the records from Hansard quoting members of the lower house in early December. It seems that this issue is now all about choice. People apparently should have the choice to access State sponsored suicide when they are considered to be suffering intolerably at the end of their lives. It is of course debatable whether choice overrides every other consideration including the safety of the vulnerable and the community at large. Choice also cuts both ways and other people should be entitled to choose to have nothing to do with the process. Such choice should be extended to not only medical practitioners but also healthcare institutions which do not wish to be associated with assisted suicide.

Thank you for reading this. I wish you and the other members of your panel all the best in your deliberations.

Yours sincerely

Christopher Middleton FRACP FAMA