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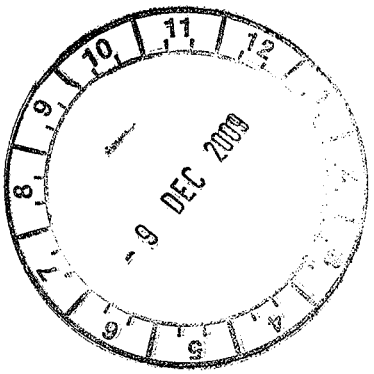

Hon Brian Ellis MLC
Chairman
Parliament House
PERTH WA 6000

2 December 2009

Dear Mr Ellis,

Thank you for your letter of 12 November 2009 inviting me to provide a short submission to support Petition No 51 which I promoted.

Attached is my submission and 5 copies of the book "Advancing the Culture of Death" – one for each member of your Committee.

John R. Barich

Encl.

STANDING COMMITTEE ON ENVIRONMENT AND PUBLIC AFFAIRS
Petition No 51 – Euthanasia
(Submission)

In preparing this submission, I was guided by the Australian Medical Association's 'Position Statement on the Role of the Medical Practitioner in End of Life Care', 2007, which clearly states: "The AMA believes that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life."(http://www.ama.com.au/web.nsf/doc/WEEN-76L9US). This sentiment is echoed even more strongly in a directive issued by the World Medical Association.(http://www.wma.net/e/policy/p13.htm)

Given the foregoing, from where is the present demand for euthanasia coming? It seems certain that it has arisen in a generation of aging children who have witnessed, at close hand, the lingering death of a parent or loved one whom they believed suffered greatly before dying. Needless to say, they themselves are not desirous of suffering a similar fate. Nor indeed do they have to. Medical technology has made impressive advances in recent times and, although by so doing it has directly contributed to creating end-of-life situations through increased life expectancy, it has also been responsible for improving the control and management of the pain which formerly accompanied these conditions.

As we have seen above, pain is not, nowadays, a major factor with which people have to contend at the end of their lives. However, there are other reasons which may lead people to contemplate euthanasia. A further factor which can be identified, especially among those with severe disabilities, is a feeling of helplessness, a perceived lack of control of their lives and a dependency upon others which may, in extreme circumstances, lead to deep-seated anxiety, despondency and depression. Clearly this is a psychological condition, and demands that people experiencing these feelings receive counselling; in much the same way that people who are depressed in the general population receive help for similar underlying problems. Only, of course, because of the import of what is being contemplated, there is a greater urgency for this type of problem to be identified and resolved speedily; both in the interest of the patient, and society as a whole. Under no circumstances should people suffering from these symptoms be encouraged to take the drastic action which is proposed in this Bill. In particular, since he was obviously suffering from these symptoms, and had made at least five attempts on his life, Christian Rossiter should not have been permitted to make contact with Dr Philip Nitschke; let alone been encouraged by the latter to take the drastic course of action upon which he eventually embarked.

A phrase often encountered in proposals surrounding Bills of this kind is 'dying with dignity'. This conveys a message to those who are terminally ill that living with terminal illness is in some way undignified; and that persons who are terminally ill are better off dead than alive. Is there any justification for this thinking? Furthermore, there is a covert suggestion, implied in the phrase 'dying with dignity' , that some lives are less worthy than others; which is definitely at odds with the democratic assumption that all people, whatever their physical disabilities, have equal dignity. I am firmly of the opinion that the consent of the Parliament to this Bill will entrench these negative attitudes in the minds of the public, to the detriment of society at large. As well, another hackneyed phrase used in this context - to which I take great exception - is 'quality of life', by which is meant that some lives are of high quality,

while others are not. Is anyone - including the medical, psychiatric and related professions - really in any position to pass judgement on what constitutes such a nebulous term as 'quality of life'; either for themselves, or indeed anyone else?

As a sop to these objections, we are informed in the Bill that there will be adequate safeguards provided to ensure that malpractice is prevented. Experience has shown that so-called 'safeguards' in euthanasia do not work. By way of example consider this article published in the "Michigan Law Review", June 2008, (http://www.michiganlawreview.org/archive/106/8/hendinfoley.pdf).
It exposes the futility of 'safeguards' in euthanasia legislation operative in Oregon, USA, and identifies, inter alia: circumvention of 'safeguards', reckless psychiatric assessment and coercion.

Legalising euthanasia will have several serious side-effects:
It will set a bad example to all; especially those who are depressed or suicidal. It will be seen as any easy alternative to living what may be perceived as a life of hopelessness; especially if euthanasia is endorsed and sanctioned by governmental decree. The Australian government spends about $10m annually on the National Suicide Prevention Strategy (according to a media release from the Hon Trish Worth, Parliamentary Secretary for Health, 29 March, 2004). This Bill directly undermines the efforts to reduce the incidence of suicide in Australia.
Secondly, it will place pressure on the sick and elderly to accede to euthanasia if, as occurs in Oregon, the Health Authority informs them that although the State's health plan does not cover the cost of medication, it covers the cost of euthanasia.(http://abcnews.go.com/Health/story?id=5517492&page=1).
There are indications that, among the elderly, suicide rates fall when there are better levels of psycho-geriatric and community services (See Pritchard, C and Hansen, L (2005): "Comparison of suicide in people aged 64-74 and 75+ by gender in England and Wales and major Western Countries 1979-1999, International Journal of Geriatric Psychiatric, Vol 20(1), pp17-25.

The history of euthanasia Bills in Australia is as follows: short-lived success in the NT, after which the legislation was overturned by the Federal government; defeat in Victoria, Tasmania and South Australia. Currently a Bill, introduced by Greens Senator Bob Brown in 2008, languishes before the Federal Parliament where the Rudd government declines to act upon it. These outcomes speak volumes for the low esteem in which euthanasia is held by the rest of Australia. The Parliament of Western Australia is surely not about to depart radically from this position?

The push for euthanasia is driven chiefly by fear of suffering. Governments should focus on allaying the fears of the sick, elderly and suicidal by ensuring that all have access to the best available care, be it palliative or psychological. They should do this by ensuring that this care continues to improve, not deteriorate. For most people, effective relief from pain and suffering in terminal care is already available. Rather than legalising euthanasia as a solution to fear, pain and suffering, legislators should be working towards ensuring that everyone receives the best possible end-of-life care, and that no one has to experience avoidable suffering. Further, it behoves the community to accept the responsibility of ensuring that persons enduring unavoidable suffering are made to feel valued for their own sake, and permitted to end their days in true dignity, rather than being despatched by a lethal injection or cocktail of drugs.