FROM THE BISHOP OF NORTH WEST AUSTRALIA
Gary Nelson
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Report of the Joint Select Committee on End of Life Choices

To Western Australians

The State Government's cross-party parliamentary committee has released their report (MY LIFE, MY CHOICE - The Report of the Joint Select Committee on End of Life Choices) recommending the establishment of legislation enabling voluntary assisted death. Further, the committee recommends that the eligibility requirement for voluntary assisted death include,

> 'that the person is experiencing grievous and irremediable suffering related to an advanced and progressive terminal, chronic or neurodegenerative condition that cannot be alleviated in a manner acceptable to the person'.

The ethical decisions surrounding 'end of life' choices are difficult for individuals who are suffering; their families, who witness the suffering of those they love; and the medical profession as they seek to care for all affected by the one who is dying. A merciful response is what people in our society desire whether, we come from a Christian perspective or otherwise. Yet determining what is truly merciful in the context of the 'common good' can not be driven simply by emotional responses to suffering and pain.

> As Christians we believe all people are created in the image of God and so are inherently valuable. As well, we believe that humans do not have the authority to take life, but only God. Thus, suicide is always a bad idea, irrespective of the manner in which it takes place. The implication of these fundamental Christian beliefs is to reject euthanasia or voluntary assisted death as the merciful or compassionate way to deal with end of life choices.

Let me present five areas to reflect on in this debate about end of life choices.

Firstly, assisted dying or unendurable pain are not the only two options as we face the suffering of terminal illnesses. Palliative Care and the technology surrounding pain relief offer other options. It is interesting that the committee's report also recommends increased access to palliative care.

Secondly, key arguments used in opposing capital punishment are paralleled in those used to defend voluntary assisted dying, such as, the irrevocable nature of death; along with the risk to minority and vulnerable groups.

Thirdly, voluntary dying always affects other people, it is never an isolated act. As humans we are essentially people in a network of relationships and death will reach deeply into our lives.

Fourthly, voluntary dying undermines the long-held ethos of the medical profession as it lessens the commitment to that overriding concern of 'causing no harm'. Once doctors become advocates for voluntary assisted dying, it will be hard to circumvent conflicts of interest, ultimately it will undermine trust in our doctors and the integrity of the health system. Perhaps this is why professional bodies such as the AMA are not supportive of doctors being involved in intervention aimed at ending a person's life.

Fifthly, overseas experience evidences a 'bracket creep' where the limits of laws keep being pushed to include more situations where voluntary assisted dying can become a legitimate option. For example, in the Netherlands patients not terminally ill can be assisted in dying while it is legal for patients not

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mentally competent to be subjects of euthanasia. Also, adolescents between 12 and 18 can request voluntary assisted dying without parental approval.

A further concern is the mixed message voluntary assisted dying ('legal suicide') sends to the young and vulnerable in our society. It seems counter-productive to spend so many resources on suicide prevention if we then choose to endorse legally any form of taking one's own life or being assisted in that act.

So, I appeal to fellow Western Australians and the Government to reject moves to legislate for voluntary assisted dying. As well, we call for more resources to be made available for increased access to palliative care, particularly for those in more vulnerable situations such as people in low income brackets, non-urban locations, acute care or nursing home settings, with ethnic or indigenous backgrounds, and the elderly.

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