

To Whom it May Concern,

I am writing to you in regard to the current legislation before the Victorian parliament concerning assisted suicide (Voluntary Assisted Dying Bill 2017). While I am not a resident of Victoria, this bill is essentially a test case for the other Australian states, and it is a matter of such importance that I feel compelled to write to all of the members of the Victorian parliament to express my concerns regarding this issue. I have some specific objections to the proposed legislation, however my major concerns are more to do with the concept itself, and I feel strongly that once the current line in the sand regarding assisted suicide is crossed, there will be no going back.

Before outlining some of my concerns, I should provide some information regarding my own background, to put my objections into context. I am a consultant anaesthetist, having completed my medical degree in 2003 and my specialist training in 2013. During my medical career I have been involved in the care and treatment of many patients with severe life-threatening illnesses, and involved in many discussions with patients, families and other staff regarding diagnosis, prognosis, treatment options & limitations, as well as end-of-life care. These discussions have occurred in multiple settings including both community and hospital facilities, emergency departments, intensive care wards, palliative care facilities, anaesthetic bays and general wards, as well as with my family and friends over the dinner table.

From my professional experience, and having looked at assisted suicide laws in other jurisdictions, I have come to the conclusion that legalising assisted suicide is not a path that Australia should go down, and I will now outline some of my reasons for this.

First, it sends a confusing message to society regarding ending one's own life. I have seen first-hand professionally and personally the devastating outcomes when people feel there is no other option in life but to end it. As it stands currently in Australia, the universal message is that no matter how bad things get, it is never okay to take your own life. There is always something that can be done to help. No matter how much pain, anguish and suffering you are experiencing the unambiguous message has always been that "There is NO level of pain & suffering above which it is okay to end your life". If the legislation passes, it will become "There is now a level of pain & suffering, namely 'x', above which it IS okay to end your life". Given that pain & suffering are by definition subjective measures, it will be very difficult, if not impossible, to decide whose condition is above 'x' and whose is not. And is it fair, or even legal, to discriminate against individuals on the basis of age, diagnosis, expected life span or the presence or absence of mental illness? Once the legal right to assisted suicide has been granted to some, there is no logical reason for it not to be granted to all.

Second, this debate is often framed as one about "autonomy"-as in, an individual should have autonomy in decisions about how they live their life, including the decision on when to end it. As a doctor, I understand how important the concept of patient autonomy is. However, in healthcare, patient autonomy is about providing relevant information to patients, discussing treatment options and goals, answering questions, and then allowing them to provide informed consent to which of those options they choose, should they decide to go ahead with treatment. It is not about the patient being able to demand particular treatment options that are not available to them, for whatever reason, especially where that option may have flow-on consequences due to costs, impact on access to care by others, or where the doctor believes the treatment is not in the best interests of the individual. Assisted suicide proponents often make arguments relating to

autonomy along the lines of “It’s my life, so it’s my decision, and everyone else should butt out!”. Or, “If you don’t agree with assisted suicide, then don’t do it. But don’t deny me my right to end my own life”. They feel their decision affects only themselves and no one else. However, leaving aside any impacts on their immediate family, it is important to remember that in a complex socio-technical system such as the modern western democracy we have in Australia, changes to legislation and the multiple individual decisions and choices that follow, can resonate through the system producing unintended consequences. Often, once something becomes legal, it eventually becomes normalised. Once normalised, it becomes normative. Once normative, it becomes expected, and once expected, it is likely that anyone who acts or believes differently will be made to feel very uncomfortable, or worse still, directly criticised and ostracised for their action or belief. There may no longer be the processes or structures available to support them in this minority position where once they were commonplace. Some of the people who had worked to make it legal or normal in the first place, will be unhappy with that end result. This has happened in the case of legalising or liberalising access to abortion. Initially framed as a way to reduce harm from illegal “backyard” abortions, over time it has transitioned into something that is now performed for reasons far removed from that original intent, and stories are emerging from women who have felt pressured in the context of “genetic counselling”, where the assumption was that they would abort their unborn child due to genetic or congenital abnormalities. Along similar lines is my concern that over time, suicide will become more accepted and normalised as people take up the option. As subsequent generations grow up in a society where suicide is becoming increasingly normalised, access to it will be further liberalised, and there won’t be the same unified position regarding those who are contemplating suicide for mental health reasons and non-terminal medical conditions. Cost-cutting might mean less funding and support services for suicide prevention, as well as palliative & aged care services, because society considers there are now more “cost-effective” alternatives. And those with terminal illness may feel they are being selfish by wanting to live longer at significant expense and inconvenience to their family and society, when a cheaper and easier option is available. And what message does it send to those who are already in the midst of long-term pain and suffering, with no end in sight, when the government says that having to endure a life like that, even for a short period, is not worth it.

Another concern I have regards a presupposition that appears to underlie the whole debate on assisted suicide. There seems to be an assumption that there is no possibility that “good” can come from pain and suffering. At one level, this seems obvious, and most people would agree that, where possible, we should avoid, or at least minimise, pain and suffering. Indeed, this is a fundamental component of medicine generally, and my speciality of anaesthetics specifically. But it doesn’t necessarily follow that because we should try to reduce or minimise suffering, that no good can come from it. You don’t have to look far for examples of people who have been through significant hardship or suffering, whether physical, emotional or psychological, but have come out the other side and are able to identify genuine good that has come as a result of, not just in spite of, the trauma they experienced. So not only are we risking significant harm with assisted suicide legislation, but it could also result in missed opportunities for good as well. Obviously this is not a universal experience, but it does show the falsity of the assumption that pain and suffering is to be avoided at all costs, because nothing good can possibly come from it. Now, one might argue, that suffering because of a terminal illness is a different situation because the person won’t be alive to experience any post-traumatic growth. However, this assumes a number of things which I think need to be challenged. The first and most obvious one is it assumes no “good” could be experienced by the patient while they are still alive. Second, it assumes we are accurately able to predict the expected lifespan and course of treatment and symptoms of the

patient. Finally, it assumes that the only relevant “good” is that which can be experienced or enjoyed by the patient, and ignores any post-traumatic growth experienced or resilience developed by the family members and carers of those looking after the patient in the lead up to their death. I think all three assumptions need to be challenged, and are symptomatic of the move towards an increasingly individualistic society where the desires and wishes of an individual are prioritised over their potential impact on those near and dear to them, as well as the wider society in which they live. This move away from a more altruistic society where we look to put the needs of others above our own is troubling, and tears at the very fabric that has held society together for many centuries. Already we seem to flee at even the slightest hint of suffering, so we never learn how to “suffer well”. This will be exacerbated if the state legalises assisted suicide.

Finally, in order to challenge some of the assumptions mentioned above, I would like you to consider the following scenario. Imagine a father of three young kids in his thirties. He is working full-time as a doctor, and supporting his wife and kids, and generally enjoying life. Out of the blue, he is diagnosed with metastatic cancer in his brain, lungs and abdomen, and is given a life expectancy of less than 6 months. Treatment options, including clinical trials, are ruled out one by one, and he undergoes palliative neurosurgery and radiotherapy. Assisted suicide is legal, and he would qualify for it if he chose to pursue it. From his career as a doctor, he knows what kind of death to expect, with significant pain and suffering, as well as a loss of function and autonomy. But he is keen to make the most of symptomatic treatments and palliative care options that are available, and to avoid sending the signal to his kids, and those around him, that when life gets tough, it is okay to end it. However, a few months later, the cancer causes a major bowel obstruction. He undergoes surgery and a stay in intensive care, but he is now a broken man, with ongoing, pain, vomiting, diarrhoea and weight loss. He decides it is all too much, and doesn't want to burden his family any more, even though they assure him they don't see it that way. But, after a short period he takes up the option to end his life that is now available to him. Those around him are sad to see him go, but are relieved to see his suffering end, and society applauds the legislation that allowed him to end his life “humanely”, and life goes on. He had a “good death”.

Imagine now, the same scenario, but with a different ending. Assisted suicide has not been legalised. He struggles on with the same symptoms post-operatively with little improvement. However, 1 month later, he unexpectedly qualifies for a clinical trial of a new cancer treatment. Despite still being very unwell, he elects to start the trial, thinking any contribution to medical science before he dies would be a worthwhile legacy for his children. Within a few weeks of the trial starting he gets sicker, and develops another bowel obstruction with more surgery and time in hospital. His symptoms worsen and nothing seems to help them. However, despite his worsening physical and mental state, the trial medication seems to be working. His tumours are shrinking. He doesn't see this as good news, as it seems it will just prolong his suffering even more, without providing an ultimate cure. He remains unwell and essentially housebound and dependent on others for a number of months. Then, slowly, but surely, his symptoms begin to resolve. New symptoms and treatment side-effects arise from time to time, but he finds he is beginning to enjoy life again. While not disappearing completely, his tumours, and side-effects, have reduced significantly. He is able to get outside and walk around, and even walk his kids to school. All of a sudden, having prepared for death, he finds himself still alive one year after diagnosis. He is able to get his drivers licence back and gain some more independence. Two-years down the track, his treatment continues. There are still some side effects, but they are manageable. Some tumours have disappeared while those that remain are stable. Amazingly,

three years down the track, he is exploring options to get back to work part-time and has enjoyed the bonus years he has been able to spend with his wife and kids. Fast-forward to the current day, over 4 years down the track. He is back working as a doctor, with an emphasis on improving patient safety in healthcare, and is now sitting at his computer writing a letter to parliamentarians about why he thinks legalising assisted suicide is a bad idea.

Yes, this has been my lived experience over the last 4 years. Despite my desire to keep emotion and anecdotes out of this debate, I feel it necessary to provide my own. I would like to think that even if assisted suicide had been an option 4 years ago, I wouldn't have taken it up, but it is impossible to say. There were some dark days then, with significant physical and emotional pain and suffering. I know my family would've been against it, and certainly wouldn't have coerced me or pressured me into it, but who knows how much pressure I would've exerted on myself if the option was available. And as far as I can tell, most assisted dying legislation worldwide, including the proposed Victorian legislation, doesn't require discussing it with family members, and the process can be completed in a relatively short time frame.

Obviously my situation is rather unique, but it does highlight how difficult it can be for doctors to predict life-expectancy, response to treatments, and what new options might lie just over the horizon. It also shows the importance of ongoing medical research into new treatments and symptom management, and raises the question of what opportunities for research and improvements in healthcare we might miss out on if people take up the option of assisted suicide. To be clear, I am not saying we should keep people alive in order to experiment on them, but rather providing an example of how genuine good, in the form of improved cancer treatments and symptom management, can arise from someone's pain and suffering, as has happened in my case. I think most people enduring suffering would be keen to see new options developed so others may not have to suffer so much in the future, and I think that would be a wonderful legacy for future generations.

So, I thank you for taking the time to consider the issues I have raised, and I hope you will take them into consideration as you consider the legislation before you in parliament. I see fundamental problems with the concept of the state assisting its citizens to end their own lives. It sends a confusing message to society, overstates the role of patient autonomy without giving due consideration to potential unintended consequences and harm that might arise, and presupposes that no good can come from suffering. Perhaps most importantly, it drastically overstates our ability to predict the future in terms of the expected life-span, progression and symptomatology of "terminal" illnesses. As I have said, in a complex society such as we have today, it is impossible for individuals to make decisions and perform actions that don't in some way influence those around them, and the wider society. The bigger the decision, the bigger the potential impact. Surely there can be no bigger decision than the one to end your own life.