T R A N S C R I P T

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

Subcommittee

Inquiry into end-of-life choices

Melbourne — 15 October 2015

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Mr Ian Wood, National Coordinator, Christians Supporting Choice for Voluntary Euthanasia.

The CHAIR — I would like to welcome Mr Ian Wood, the national coordinator of Christians Supporting Choice for Voluntary Euthanasia. Thank you very much for being with us today, Mr Wood. Before I invite you to make some opening remarks, I will just caution that all evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. Therefore you are protected against any action for what you say here today, but any comments made outside the hearing are not afforded such privilege. Today's evidence is being recorded. You will be provided with a proof version of the transcript in the next week. Transcripts will ultimately be made public and posted on the committee's website. We have allowed approximately 45 minutes for you today, so I would invite you to make some opening remarks and thereafter the committee will have questions.

Mr WOOD — Thank you for the opportunity to be here today. I am here on behalf of the group Christians Supporting Choice for Voluntary Euthanasia. I am a retired community pharmacist and am 74 years old. As well as being the national coordinator, I am also the co-founder of the group.

My interest in voluntary euthanasia started in 2004, when my mother was dying, essentially from starvation after nearly eight years with Alzheimer's. I thought there had to be a better way of dying, and there is. This is on page 9 of my submission. At that time I urged my local MP to come and visit my mother regarding changing the law. He did not come.

Some years later I read a letter from Cardinal Ratzinger — later Pope Benedict XVI — to some American bishops, saying that killing in a war or capital punishment could be justified but never an assisted death. I wrote to Reverend Trevor Bensch at the church I attended in Adelaide, saying I had a problem with that theology. He agreed it was illogical and inconsistent. Later again, in 2009, Reverend Trevor Bensch and I co-founded the group Christians Supporting Choice for Voluntary Euthanasia, based on his experiences as a hospital chaplain, to give the majority of Christians who do support VE and assisted dying a voice to counter the powerful and vocal minority who oppose choice on religious grounds. We have in excess of 1100 members from every state and territory, and membership includes a number of ministers of religion, the most prominent of whom is our patron and member of the executive, Reverend Dr Craig de Vos.

In my opening remarks I would just like to make a few brief observations on other submissions made to this inquiry. Those by Catholic groups all expressed strong opposition to choice in dying. I, speaking on behalf of my members, do not have any problem with them not agreeing to an assisted death, but we do strongly resent their assuming that they have got the right to impose their views on everyone. A number quoted the section that refers to 'do no harm' from the Hippocratic oath, but they also chose to ignore the section of the oath that forbade women from becoming doctors. Also the same oath forbade doctors from using the knife, or surgery, because at that time surgery was considered to be the role of barbers. I submit that allowing a person to die with terrible suffering because of a refusal to permit to an assisted death is in fact doing harm.

A number of form letters included a prayer that God would influence the Victorian MPs not to approve VE or assisted dying. In my handout A I note that a Dr Olvera in California, whose young daughter died a terrible unnecessarily traumatic death from cancer, was also praying to God that God would influence the Californian MPs to approve assisted dying. Obviously this presents God with somewhat of a dilemma. Interestingly, the California legislation passed.

Many of the submissions oppose talk of pressure on the allegedly vulnerable. I address this on page 7 of my submission, but I would add that many doctors in the palliative care system do exert enormous multifaceted pressure on the dying for them to accept the palliative care regime and be grateful. Please note that 93 per cent of Oregonians who utilised an assisting death are also enrolled with hospice care, so they obviously want the choice. The submissions supporting voluntary euthanasia or assisted dying all want choice and are almost invariably the result of a death of a close friend or a family member where they endured futile or unnecessary suffering.

Many submissions against choice in assisted dying refer to the 'slippery slope'. The suggestion that if we start off with restricted criteria invariably this will expand and 'the next thing you don't know who will be getting killed off' is their usual expression. It is one that I do not use. I submit that pages 48 to 50 of submission 660 of the Royal Society of Canada contains an extensive and authoritative rebuttal of this fearmongering.

Also I have asked that a copy of *Our Right To Die — Lessons for Britain from the European Experience*, prepared by Chris Davies, a member of the European Parliament, be handed to you. This I believe very thoroughly addresses many of the concerns raised by some of the submissions.

I could comment at length on what I call either misrepresentation or a distinct lack of facts and data in some submissions, especially relating to Catholic, Presbyterian and Anglican groups, but I will restrict myself to one that I feel is quite typical. Submission 355 by the Social Responsibilities Commission of the Anglican Diocese of Melbourne includes:

> The Royal Dutch Medical Association (KNMG), which represents doctors in the Netherlands, has said that of the 175 000 babies born every year in the Netherlands, about 650 might be cases which would warrant euthanasia.

This is not what KNMG stated. Their actual statement included:

> Around 175 000 babies are born each year in the Netherlands.

They got that bit right.

> Most of them are perfectly healthy, but around 650 infants will die, usually as a result of very severe congenital defects —

this is quoting the actual statement —

> and in spite of the best possible intensive care treatment.

This viewpoint, the protocol, sets out a professional standard for treatment of newborn infants with serious birth defects where their suffering is extreme and where further life-prolonging treatment would be considered medically futile.

I have not got a copy of this, but I would suggest that you refer to a comparison between an infant with extreme birth defects dying in the Netherlands compared with the USA in a document called *Examining the Groningen Protocol* by Darin Achilles.

I would like to comment briefly on three points in the transcript of the Australian Christian Lobby by its witness Dan Flynn. To quote:

> … the deliberate and direct intervention of a doctor resulting in death is something that is simply not supported, not only by the Australian Christian Lobby but by a broad base certainly of the Christian constituency in Victoria.

I would ask you to refer to page 2 of my submission for the facts — that is, support among Anglicans is actually higher than in the general community. Also the ABC Vote Compass at the last Victorian election is a very strong endorsement of Christian support as well as community support for assisted dying.

Another quote from Mr Flynn is:

> The preferred safeguard in that Belgium act was intolerable pain.

If Mr Flynn actually read the Belgium act, he would find that the definition, the criterion, is that the patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident. This actually happens to be my preferred criterion, so he is wrong there. Finally, Mr Flynn said:

> Yes, I do hold my submission that food or drink ought to be administered by a PEG if it is being assimilated into the body.

Frankly, I think this is absurd. I should be able to specify that I do not want PEG feeding in my advance care directive if I am in an advanced state of dementia. In fact I have this in my ACD, along with a verbal request to my medical power of attorney that the doctor be sued for assault if a PEG tube is inserted.

I have many letters on file describing horrific deaths endured by members of family and friends — members of our group. I have just handed out handout B as evidence of just one of these — the torturous death of Murray who lived next door to me as a child and who was my best man at my wedding. I think Mr Lovell's story is even more traumatic than Murray's, but there we go.

There can be no doubt that the facts, ranging from an individual death such as Murray's to the Quebec parliamentary inquiry that led to the act respecting end-of-life care, the recent California end-of-life bill and also the recent Canadian Supreme Court decision should lead to a change in the law in Victoria to extend the range of end-of-life choices to include assisted dying.

In conclusion, I bring to the attention of the committee the fact that on Monday, 5 October 2015, the Californian governor signed an end-of-life bill, giving 38 million Americans the right to choose an assisted death. Of particular interest to our group is that Governor Brown received support for passing the Californian bill from Archbishop Desmond Tutu, and also significantly Governor Brown, who actually had the power to veto this bill, is a committed Catholic and previously had training as a Jesuit priest. His stated reasons for approving the bill included:

> In the end, I was left to reflect on what I would want in the face of my own death. I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn't deny that right to others.

It is my hope that this committee, and later Victorian MPs voting in support of an assisted dying bill in some form, would include such a reason with their support.

The CHAIR — Thank you, Mr Wood, for your submission. I start by making an observation in relation to your comments about Mr Flynn, that Mr Flynn has provided supplementary information to the committee following questioning from Mr Mulino. I make that observation as the first point.

Mr Wood, I would be particularly interested, given the organisation that you represent, if you could crystallise in a succinct way the underpinning Christian doctrine that supports your position.

Mr WOOD — It is not so much doctrine, but our general approach is the one that is actually on the front page of our little booklet. We say:

> Love and compassion dictate that the legal option of an assisted death should be a right for all Australians with a hopeless or terminal illness.

I think that that is a compassionate choice whether you are a secular, Christian or anything.

Mr MULINO — Thank you for your submission and for your evidence. Taking a step back from voluntary euthanasia for a moment before I ask the couple of questions on that, one of the concepts that we have received evidence on from a number of sources, not just from people commenting on religious doctrine but also from ethicists, is this concept of double effect. There seems to be quite broad support for the notion that if you are giving pain relief with the intention of reducing pain but that you know it may well facilitate death, that that is ethically justifiable. Some people have suggested that it would be good to clarify the legal position so the medical practitioners can use the full range of pain relief options available to them without fear of legal consequences. What is your position on that doctrine, and do you think it would be useful to clarify the position?

Mr WOOD — I would certainly agree that it would be useful to clarify that, to remove any fear that by increasing the dose of any sort of medication, as in the case of palliative sedation when you are putting a person into a coma until they starve to death. That is essentially what the procedure is. I think certainly they need clarification so that they are not facing a possible murder charge, because it is really just a matter of how the doctor expresses intent. They can give the same dose of medication as long as they say they are doing it to relieve the patient's suffering. That is okay; that is within the law. If they gave the same medication exactly and said, 'They did actually say that they'd like help to die and I have given them that help', that would result in a murder charge. That is an absolutely ridiculous situation. Dr Rodney Syme addressed it far more comprehensively than I can. He has written a whole treatise on it I suppose you would call it.

The CHAIR — We are aware of Dr Syme.

Mr WOOD — You are aware of that. It is interesting, I spoke to my GP some time ago about that very situation and his description of it was, 'It's a cop-out'.

Mr MULINO — Just on the issue of euthanasia, could you clarify the limitations that you think would be appropriate for when it should be available?

Mr WOOD — My personal preference, if I was ever in a situation where I needed help to die, I would go for the one Dr Erica Preisig in Switzerland uses. She was a member of Dignitas, and she has sort of branched out on her own. In her situation, she sets up an IV line with the patient, with saline. The patient practises turning the tap with saline, and then she replaces the saline with phenobarbitone and she says, 'Now you realise if you turn on the tap now that you will die?'. If the person turns on the tap, then they die virtually within minutes, because it is intravenous.

The reason why she chose intravenous instead of the normal method of just taking a dose of the same medication is that it can be very bitter, and she thinks quite compassionately that the last experience of a person on earth should not necessarily be a bitter-tasting drug. Now, that sort of makes sense to me. Of course the other possibility with oral pentobarbitone is that you can occasionally vomit it, and so that means you need to precede the dose of the pentobarb with an anti-nausea ingredient half an hour beforehand. You do not need to worry about that with intravenous.

From the point of assisted dying versus voluntary euthanasia, from the safeguard point of view, self-administration should be the first choice, but on the other hand I do think there are occasions where a person perhaps is no longer physically able to ingest the medication or even turn on the tap. There should be some proviso, perhaps with even greater safeguards, that the doctor can assist in that circumstance.

Mr MULINO — Do you think it should be limited to people who are terminally ill?

Mr WOOD — No, as I said in my opening statement, my suggestion would be in the ideal situation the Belgian limitation. Certainly for a person with a terminal illness it is interesting. Alzheimer's Association actually classes Alzheimer's as a terminal illness. Now that is a fairly grey area because it is so progressive that obviously in the latter stages of dementia a person cannot make an active decision. This is where I quite like the opportunity that Hugo Claus had, the person that I mentioned in my submission. In that window between a firm diagnosis and getting to the stage where a person can no longer make an active request, he had the opportunity to die singing.

Ms PATTEN — Thank you, Mr Wood, that has been really informative and I enjoyed reading your submission as well. I think I understand, but just to clarify if we were to move ahead with some form of law reform in this area, the model that your organisation would support would be something similar to the Oregon model but with the Belgian provisions or qualifications on top of that.

Mr WOOD — Yes, the Oregon model is strictly limited to self-administration for a patient expected to live for less than six months.

Ms PATTEN — You would expand it to where Belgium is?

Mr WOOD — I would like to expand it to include a hopeless illness or an incurable illness — any illness where there is no hope of cure.

Ms PATTEN — And the same sort of model — two doctors, independent?

Mr WOOD — Two doctors, independent.

Ms PATTEN — Competent mind?

Mr WOOD — Yes, you can have the provision that they had in the Northern Territory bill, a mandatory examination by a psychiatrist, although that is probably not really necessary. I think having an advance care directive is another ideal way of clarifying in advance what your wishes are going to be, and of course an advance care directive only comes into action if the person is not capable of actually verbalising their request at the time, which is something some people seem to overlook with advance care directives. It only comes into effect if you are unconscious, virtually.

Ms PATTEN — Would you support assisted dying being in an advance care directive? In most advance care directives it is a refusal of treatment.

Mr WOOD — I think that you should be able to ask for it, yes.

The CHAIR — Mr Wood, is there anything further you would like to add before we conclude our session, anything that has not been covered?

Mr WOOD — The only thing that I would like to add is that this is a marvellous opportunity for the Victorian government to be progressive. I did come from South Australia, and South Australia, way back many years, was one of the first states to introduce votes for women and this sort of thing. I think Victoria has the opportunity here to enact some compassionate legislation giving choice, which will not be utilised by very many people but will be incredibly important for a lot.

The CHAIR — Thank you, Mr Wood, for your submission.

Witness withdrew.