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ECCWA Submission on Voluntary Assisted Dying

Suresh Rajan on behalf of ECCWA

Voluntary Assisted Dying

1 Background:

1.1 The Ethnic Communities Council of WA is the state's peak ethnic umbrella organisation and its objects include inter alia:

- To act as the peak body for ethnic communities in Western Australia, that shall advocate for the rights of ethnic communities in ensuring the protection of these rights.
- To ensure the rights of the ethnic communities including effective participation in decisions which affect them, and encourage the sharing of community resources.
- To do and to perform all acts, matter and things as are charitable and for benevolent purposes having public benefit in accordance with the law of the State of Western Australia and the law of the Commonwealth of Australia and to disseminate any information within a Social Justice framework that achieves the objectives of the Council in ensuring equity and access to and for ethnic communities.

In fulfilling these objects the Council has responded to many inquiries, consultations etc. organised by state and commonwealth government agencies. The Council places a strong emphasis on Human Rights and would strongly argue that a Human Rights framework is essential for addressing this issue and other such social conditions effectively. It is from this perspective that the Council is pleased to respond to the above matter.

We have not had the time and resources to do a comprehensive survey of our members but have relied on matters conveyed to us by our Management Committee who are delegates of many of our member associations.

2. Submissions:

As an overarching principle our council is of the view that there are very grave dangers in the issue and definition of "Capacity" to make decisions relating to "End of Life" decisions. Currently people with disabilities and Chronic and terminal conditions are over represented in the statistics relating to assisted suicide. Issues of cognition that may impact on capacity does call into question the capacity of some people to make that decision. As a consequence we question the "voluntary" nature of the life ending decision. **This position leaves our status as being one of qualified support. Support for the relief of pain and suffering attributes of VAD but ensuring that the legislation addresses the issue of capacity to categorically confirm the "voluntary" nature of the decision and the informed nature of the decision.**

We also note that our colleagues in the Disability sector, PWDWA and AFDO have publicly stated their position as follows:

"All respondents (to their consultations) had some experience of loved ones going through palliative care, or themselves experiencing illness that led them to prepare for death. When asked directly if they agreed that a person should be able to end their life or be assisted to end their life when they choose, all but one said yes. However, when asked if people with disability were or could potentially be treated differently in a palliative care environment, all but one thought that people with disability would and are treated differently and that this was concerning. The concern was around people with disability not being included and part of the decision making about their care, and the view of a person's quality of life by health

professionals. “Many “Normal” people do not understand that a person with a severe/ moderate or intellectual disability can still have a quality life, as their perception of quality of life is compared to their normal life.”

One of the other issues that go to the notion of “informed” decision making centres on English Language capacity. Medical and health issues are couched and contained within language that is complex and often difficult to understand. A substantial proportion (over 30%) of our community is from a Non English Speaking Background (NESB). These people may well be still unable to fully comprehend the issues involved in the making of this decision. We therefore caution that there must be provision of interpreters on ALL occasions when there is an issue of language capacity.

Additionally, ECCWA believes that when these matters are discussed between the medical fraternity and the patient it is imperative that family members be allowed to attend these meetings. The family relationships and structures can be significantly different between cultures. The legislation is predicated on an Anglo-Celtic paradigm of family structure. This process must be adapted to take the family relationships CaLD communities into account.

Some of the direct feedback from our CaLD community representatives is as follows:

“Christian views to VAD

From a Christian perspective, liberalising the law on Euthanasia / Voluntary Assisted Dying would be hugely problematic for the following:

- **Human life bears God’s image** and it is not for us to terminate.
- According to the Christian worldview **we are part of community** joined to each other. We are not autonomous. The decisions we make impact other people.
- If the law was changed there would be a **great risk that people would feel pressured into accessing assisted suicide or VAD.**

Alternatively, the Christian view understands the value because God has created human being in his own image. Human beings are godlike beings, possessing a range of faculties (rational, moral and social) which distinguishes from animals. In particular, there is the capacity to establish and maintain relationships of love because human are made in the image of God, who is love.

There are a number of religious views on VAD, but from a biblical perspective, God has made human beings rational and volitional. Human have a God-given mind and will through which they live their lives by choice and not coercion. Human being are accountable to God for their decisions. Human beings need to qualify with an understanding and appreciation of freedom, dependence and life.

Buddhists

Buddhists are anonymous in their view of VAD, and the teachings of the Buddha don't explicitly deal with it. Most Buddhists are against involuntary VAD.

The most common position is that VAD is wrong, because it demonstrates that one's mind is in a bad state and that one has allowed physical suffering to cause mental suffering.

Meditation and the proper use of pain killing drugs should enable a person to attain a state where they are not in mental pain, and so no longer contemplate a suicide.

Buddhists argue that helping to end someone's life is likely to put the helper into a bad mental state, and this too should be avoided. Buddhism places great stress on non-harm, and on avoiding the ending of life. The reference is to life - any life - so the intentional ending of life seems against Buddhist teaching and VAD should be forbidden. Certain codes of Buddhist monastic law explicitly forbid it.

Karma

Buddhists regard death as a transition. The deceased person will be reborn to a new life, whose quality will be the result of their karma.

This produces two problems. We don't know what the next life is going to be like. If the next life is going to be even worse than the life that the sick person is presently enduring it would clearly be wrong on a VAD, as that shortens the present bad state of affairs in favour of an even worse one.

Contemporary non-Christian

There is no inherent absolute or intrinsic value to human life. There are still some recognition and support an importance value to human life. The view of human 'value' based on 'best interests'. There is a distinction between what causes pleasure or pain and what gives life a meaning. In many respects this kind of viewpoint is an attempt to create a secular understanding of human value.

Fear

One of the strongest incentives of those campaigning for VAD as well as majority of Ethnic community is that they are fearful of seeing those they love enduring a horrid, distressing and lingering death. The fear could be broken down into three areas:

- Fear of uncontrollable and unbearable pain.
- Fear of indignity and being subjected to the dehumanizing and
- Fear of dependence on family members and society in general

Autonomy

Advocates of VAD believe that all human beings have the right to exercise their own decision as to how they want to dispose their own life. No other individual or institution should have the power to infer or circumvent this right. When an individual decides to take his or her own life it has a profound and unavoidable effect on the lives of those around them. That same individual exerting their right to autonomy has removed the same right from the survivors. These views are non-heterogeneous.

We also note the following position from the Royal Australian College of Physicians and support their position as well:

"The RACP takes the following unified positions if and where voluntary assisted dying is legalised:

- Every patient should have access to timely, equitable, good quality end-of-life care, with access to specialist palliative care where appropriate. These services must not be devalued.
- On the specific issue of a competent adult in the last stages of incurable illness requesting voluntary assistance to die, the RACP supports a clinical approach of critical neutrality to encourage reflective dialogue.
- Although physicians should not be forced to act outside their values and beliefs, they also should not disengage from patients holding different values and beliefs, without ensuring that arrangements for ongoing care are in place.
- Patients seeking voluntary assisted dying should be made aware of the benefits of palliative care. Referral to specialist palliative care should be strongly recommended but

cannot be made mandatory. Voluntary assisted dying must not be seen as part of palliative care.

- Legitimate concerns exist around protection of vulnerable individuals or groups. Government, society and physicians must ensure that specific groups have equitable access to palliative and end-of-life care, and that relationships of trust are not jeopardised. Specific regard must be given to cultural and Indigenous experience.
- All physicians must affirm the value of all patients' lives, exploring reasons for requests for voluntary assisted dying, while remaining alert to any signs of coercion and reduced capacity.
- Assessments must not follow a 'tick box' approach. They must be underpinned by adequate physician-patient relationships, including appropriate training, skill and experience.
- Support, counselling and conflict mediation services must be available for individuals, families and health professionals involved.
- There must be rigorous documentation and data collection to enable review of any scheme and to assess changes in practice and the impacts on health professionals, patients and families."

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On behalf of the Ethnic Communities Council of WA