



CATHOLIC ARCHDIOCESE OF MELBOURNE

Submission to the Legal & Social Issues Committee
Inquiry into End of Life Choices

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EXECUTIVE SUMMARY

The Catholic Archdiocese of Melbourne is pleased to submit the following to the Legal & Social Issues Committee on the Inquiry into End of Life Choices.

Our recommendations are:

1. Euthanasia and its corollary, physician assisted suicide (PAS), represent a rupture from traditional medicine. Euthanasia should be rejected as incompatible with the dignity of each person and the common good that is served by respecting each and every life.
2. Refusal of overly burdensome or futile treatment is not euthanasia. This point is often misunderstood, in both the health sector and broader community, and needs to be addressed.
3. Funding should be provided so that all Victorians have access to timely, coordinated and responsive palliative care.
4. Greater education is needed around palliative care: what it is, how effective it is, when it should be employed and how to access it.
5. Legislation or regulations related to advance care planning should respect the values of the patient without legally binding health professionals to specific treatments.
6. Advance care planning forms should be descriptive rather than prescriptive, because it more accurately reflects the fluid nature of end of life care.

1. BACKGROUND: CATHOLIC APPROACH TO END OF LIFE CARE

The Catholic Archdiocese of Melbourne is grateful for the opportunity to make a submission to the Legal and Social Issues Committee on the Inquiry into End of Life Choices.

This submission is from the Episcopal Vicars for Health, Aged and Disability Care and Life, Marriage and Family on behalf of Archbishop Denis Hart and endorsed by the bishops of Sale, Sandhurst and Ballarat.

In April this year, the Auditor-General's *Palliative Care* report found the majority of palliative care is carried out by non-government providers,¹ including the Catholic Church. In Victoria,

¹ Victorian Auditor General, 2015, *Palliative Care*, accessed <http://www.audit.vic.gov.au/publications/20150415-Palliative-care/20150415-Palliative-care.pdf>, p ix.

the Church operates 26 hospitals along with 89 aged care, hospice and palliative care facilities.²

The Catholic Church follows Jesus' call to "comfort the sick" and the duty to look after those who are, in Pope Francis' words, "on the margins" of society.³ In his address to the Pontifical Academy for Life on 5 May, Pope Francis spoke of the unique role of medicine:

Medicine has a special role within society as a witness of the honour that is due to elderly persons, and to every human being ... there is no more important duty for a society than safeguarding the human person.⁴

Catholics believe that the human person is a unity of body, mind and soul. For this reason, health care should not focus solely on the body (with symptom control), but also provide emotional and spiritual support.

Catholic health services apply this holistic understanding by uniting medical expertise with pastoral and spiritual care.

This is especially true for palliative care, where the medical focus shifts from cure to comfort. In respect to the patient's overall wellbeing, end of life carers must not impose treatment that is over-burdensome or futile and they must never deliberately withdraw treatment to hasten death.

Catholic Health Australia (CHA) summarised this balance:

Since good medicine treats a *person* rather than a condition, respect for persons requires that they neither be under-treated nor over-treated; rather, when people are dying they should have access to the care that is appropriate to their condition.⁵

Catholics also recognise that human beings live, interact and die in the context of a community. This recognition impacts on end of life care in two ways. First, best practice care will attempt to surround the patient with a supportive community at the end of life. Second, it is understood the death of a person does not only affect the individual, but also family, friends, health care providers and the wider community. Catholic health care is "communitarian": we see the patient in the context of community rather than in an "individualistic" mode which could treat people as an isolated or detached unit.

² Australian Catholic Bishops Conference, 2015, *The Official Directory of the Catholic Church in Australia 2015-6*, p 797.

³ Matthew 25:36; Pope Francis, 2015, Homily delivered to new Cardinals, St Peter's Basilica, 15 Feb, accessed www.vatican.va

⁴ Pope Francis, 2015, 'What is a man worth?', Address to the Pontifical Academy for Life, May 2015, accessed <http://www.news.va/en/news/pope-francis-to-the-pontifical-academy-for-life-wh>

⁵ Catholic Health Australia, 2001, *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, accessed <http://www.cha.org.au/images/resources/Code%20of%20ethics-full%20copy.pdf>, p 42.

The Catholic understanding is summarised by Saint John Paul II and repeated by Pope Francis in May 2015:

“Respect, protect, love and serve life, every human life! Only in this direction will you find justice, development, true freedom, peace and happiness.”⁶

2. EUTHANASIA

For this submission we define euthanasia as an act or omission which, of itself or by intention, causes death in order to eliminate suffering. It can take the form of either:

- active euthanasia: intentionally taking a person's life by administering of a drug or removal of treatment, this could be voluntary or involuntary.
- physician assisted suicide (PAS): assisting the death of a person without administering any fatal treatment. This could be by obtaining drugs, supplying drugs or explaining how to administer fatal drugs.

We agree with the World Medical Association that euthanasia is incompatible with the practice of medicine as it involves a deliberate act with the intention to kill.⁷

As a particular speciality of medicine, palliative care is also incompatible with euthanasia.

Advocates of euthanasia argue that euthanasia allows the patient to “die with dignity”. We respond that no death is undignified. A person's dignity is not dependent on health, or mental state, or pain threshold, but on the fact that they are a non-repeatable human being. Euthanasia is not compassionate. It is the admission of a society's inability to provide proper care to those at the end of life, and it has no place in Victoria.

2.1 THE DANGERS OF EUTHANASIA

Australian Parliaments have recognised the inherent dangers of euthanasia, with only one of 30 euthanasia proposals over the last 20 years in Australia being passed, with that one being repealed two years later (see Annexure A). Since this time, the lived experience of Belgium, the Netherlands, Switzerland and Luxembourg⁸ show that the law cannot contain the abuses stemming from such a radical departure from traditional medical ethics.

We outline our major reasons for rejecting euthanasia below:

⁶ John Paul II, 1995, *Evangelium Vitae*, Encyclical Letter on the Value and Inviolability of Human Life, accessed www.vatican.va

⁷ World Medical Association, 2015, 200th World Medical Association Council Session, Oslo, Norway, accessed <http://www.wma.net/en/30publications/10policies/e13/>

⁸ Pereira, J., 2011, 'Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls', *Current Oncology*, 18(2); April, p 38-45, accessed <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3070710/>; Boer, T., 2014, 'Assisted Dying: Don't Go There', full text printed in *Daily Mail*, 10 July, accessed <http://www.dailymail.co.uk/news/article-2686711/Dont-make-mistake-As-assisted-suicide-bill-goes-Lords-Dutch-regulator-backed-euthanasia-warns-Britain-leads-mass-killing.html>

- **Legalising unjust discrimination:** *The Crimes Act 1958* holds that it is a criminal offence to aid and abet another's suicide.⁹ Victorian law currently offers an appropriate balance between the need to denounce the practice of euthanasia and recognising the difficult circumstances which can face those dealing with end of life issues. On the other hand, any change to the law legalising euthanasia would effectively establish a class of people whom it is legally permissible to kill. It would also undermine the efforts of community based (and often government-funded) programs, which seek to prevent suicide with a contradictory message.
- **The doctor-patient relationship is changed:** The "do no harm" principle establishes a significant bond of trust between doctors and patients. Euthanasia erodes this bond when the person who heals becomes the person who kills. Indeed, the WMA reaffirmed in April 2015 that euthanasia is unethical and incompatible with the dignity and practice of medicine.¹⁰
- **Remote and rural citizens need better care, not euthanasia:** Evidence shows that requests for euthanasia are proportionate to the availability of symptom control.¹¹ Residents in areas where there is limited palliative care will have their decisions influenced by what is available, rather than what they would prefer.
- **Euthanasia attacks the vulnerable:** Loneliness, depression and fear of being a burden consistently list higher than "pain" as reasons for seeking euthanasia.¹² Euthanasia paves the way for easy discrimination of vulnerable groups, including people with disabilities, the elderly, the lonely, and those with mental illnesses. These fears and concerns are treatable, and not insurmountable. We urge the promotion of holistic palliative care which has physicians, friends, family and community providing support and encouragement to the patient in their final stages of life.
- **Safeguards do not work:** Proposed "safeguards" for the use of euthanasia—that the patient be terminally ill, have consulted with a psychiatrist, be of sound mind, well informed, free from duress and be able to change their mind at any time—echo the safeguards put in place in Belgium in 2002. In just over a decade, Belgium now allows euthanasia for children,¹³ patients with autism, anorexia, borderline personality disorder, chronic-fatigue syndrome, partial paralysis, bi-polar disorder, and people who are "tired

⁹ Crimes Act 1958 section 6B(2).

¹⁰ World Medical Association.

¹¹ Ganzini, L., Nelson, H., Schmidt, M. et al., 2000, 'Physicians' experiences with the Oregon Death with Dignity Act', *New England Journal of Medicine*, 324, p 557-63.

¹² Ganzini et al., p 560.

¹³ Dan, B., et al, 2014, 'Self-requested euthanasia for children in Belgium', *The Lancet*; 383, p 671-2.

of life”.¹⁴ Almost 30 per cent of cases of euthanasia in Flanders now occur without explicit consent¹⁵ and only half the euthanasia cases are reported as legally required.¹⁶

- **Heavy reliance on mental health infrastructure:** Mental health services in Victoria are already overloaded. Mental illness and requests for euthanasia are often linked.¹⁷ Considering that euthanasia laws rely on psychiatric consultation as one of its safeguards, to increase the burden on a system already struggling to meet demand will create an immediate pressure to relax or ignore safeguards.
- **Death tourism:** Given no other Australian state or territory has legalised euthanasia, any change to Victorian law risks turning Victoria into a national and international destination for death.

2.2 CONFUSION AROUND EUTHANASIA

There is often confusion between refusal of treatment and euthanasia.

A report published in February 2014 found that 29 per cent of care professionals did not believe people had a right to refuse food or fluids as part of overly-burdensome treatment,¹⁸ even though patients have a right to refuse these under the *Medical Treatment Act*.¹⁹

Currently, up to 80 per cent of patients who die in intensive care units have treatment withheld or withdrawn when death is imminent and treatment futile.²⁰ Yet the report mentioned above found that 13 per cent of care professionals did not think they could administer appropriate pain control that may have the unintentional side effect of hastening death, legally in Australia, and 14 per cent were unsure,²¹ demonstrating that many doctors are confusing proper pain management, or withdrawal of futile treatment, with euthanasia.

¹⁴ Aviv, R., 2015, 'Who has the Right to a Dignified Death?', *The New Yorker*, June 22, accessed <https://www.newyorker.com/magazine/2015/06/22the-death-treatment#>.

¹⁵ Chambaere, K., Bilsen J., Cohen J., et al, 2010, 'Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey.' *CMAJ* 182, p 895–901.

¹⁶ Smets, T., Bilsen, J., Cohen, J., et al, 2010, 'Reporting of euthanasia in medical practice in Flanders, Belgium'. *BMJ*, 341:c5174.

¹⁷ van der Lee, M., van der Bom, N.B., et al, 2005, 'Euthanasia and Depression: A Prospective Cohort Study Among Terminally Ill Cancer Patients', *Journal of Clinical Oncology*, Volume 23(27), September 20 2005, accessed <http://jco.ascopubs.org/content/23/27/6607.full.pdf+html>.

¹⁸ Alzheimer's Australia, 2014, 'End of Life care for People with Dementia: Survey Report February 2014', https://fightdementia.org.au/sites/default/files/EOI_ExecSummary_Web_Version.pdf, p 9.

¹⁹ *Medical Treatment Act* 1988 (Vic) 5B.

²⁰ Brieva, J., Cooray, P. and Rowley, M., 2009, 'Withholding and Withdrawal of Life-sustaining Therapies in Intensive Care: An Australian Experience'. *Critical Care and Resuscitation*, 11(4), p 1441-2772, accessed http://www.cicm.org.au/CICM_Media/CICMSite/CICM-Website/Resources/Publications/CCR%20Journal/Previous%20Editions/December%202009/09_2009_Dec_Withholding-and-withdrawal.pdf.

²¹ Alzheimer's Australia.

Informed debates about euthanasia cannot be held, in the context of this confusion.

Across jurisdictions that have legalised euthanasia, 0.2–3 per cent of the population request euthanasia²² while an estimated 69–82 per cent of Australians will require palliative care.²³

Confusion and debates over euthanasia prohibit useful end of life conversations over withdrawing treatment and increasing pain relief for the terminally ill²⁴ which will affect the majority of Australians.

We strongly encourage training, education and public awareness to address this.

3. PALLIATIVE CARE: TRUE CARE

The World Health Organisation (WHO) defines palliative care as an approach that seeks to improve the quality of life of terminally ill patients and their families through the relief of pain and other distressing symptoms—physical, psychosocial and spiritual.²⁵

Pope Francis points to the holistic benefits of palliative care:

Palliative care recognises the value of the person ... medical knowledge is truly science, in its most noble sense, only if it finds its place as a help in view of the good of man, a good that is never achieved by going “against” his life and dignity.²⁶

He continues on to say how it provides care and support for the elderly who “for reasons of age, often receive less attention from curative medicine, and are often abandoned.” He speaks of this abandonment as an injustice, “those who helped us to grow must not be abandoned when they need our help, our love, and our tenderness.”²⁷

For this reason, palliative care is practiced across our 26 hospitals and 89 nursing and convalescent homes.

The Auditor General’s 2015 *Palliative Care* report found that while Victoria was a “leader in palliative care provision in Australia” there was still considerable room for improvement.²⁸ One service reported waiting lists of up to six weeks while another study found that

²² Swerissen, H. and Duckett, S., 2014, *Dying Well*, Grattan Institute, <http://grattan.edu.au/report/dying-well/>, p 15.

²³ Murtagh et al, 2014, ‘How many people need palliative care? A study developing and comparing methods for population-based estimates’, *Palliative Medicine*, 28(1), p 49-58.

²⁴ Swerissen, H and Duckett, S., p 15.

²⁵ World Health Organisation, 2015, ‘Definition of Palliative Care’, accessed, <http://www.who.int/cancer/palliative/definition/en/>. The ethos of Palliative Care was well summarised by its modern day founder, Dr (later Dame) Cicely Saunders (1918-2005), who said: “We will do all we can not only to help you die peacefully, but also to live until you die.”

²⁶ Pope Francis, ‘What is a man worth?’

²⁷ Pope Francis.

²⁸ Victorian Auditor General, p x.

Victorian response to patient enquiries was lower than the Australian average; where only 75.8 per cent of patients were called back within 24 hours compared to 84.3 per cent average in Australia.²⁹

We have identified three recommendations from this report as crucial in improving patient choices in end of life care.

- **Facilitating patient preference to die at home:** The *Palliative Care* report noted that while 67 per cent of people who died in a palliative care service expressed the wish to die at home, half of those were unable to do so.³⁰ A broader study showed that only about 14 per cent of people die at home, while 54 per cent die in hospitals and 32 per cent in residential care.³¹ We support increased funding and programs that enable people to die at home.
- **Closing the gap on rural palliative care:** There is a difference between the availability of palliative support available in rural areas compared to metropolitan. A report by the Australian Institute of Public Welfare reported between 0.2–0.3 palliative care specialists per 100,000 patients compared with 0.5 in major cities.³² Initiatives like the Department of Health & Human Services' (DHHS) Rural Palliative Care Medical Purchasing Fund and the Victorian Palliative Care Nurse Practitioner Collaborative are positive steps in this direction. We support these and other programs that seek to address this gap.
- **Limited family/carer support:** Death does not only affect the individual, but has flow-on effects for family, friends, professionals and carers. It is a communal reality. Patients often feel concerned about the effects of their illness/treatment on others and for this reason, fear of being a “burden” is a common reason cited for refusal of treatment, or even euthanasia³³. We support any initiatives which improve support for family and carers during this difficult time.

There is still some way to go in the adequate provision of palliative care. All Victorians should have timely, coordinated and responsive access to palliative care and we encourage any funding that gives Victorians access to the palliative care they require.

²⁹ Victorian Auditor General, p 19.

³⁰ Victorian Auditor General, p 17.

³¹ Broad, J.B., et al, 2013, 'Where do people die? An international comparison of the percentage of deaths occurring in hospital and residential care setting in 45 populations using published and available statistics', *International Journal of Public Health*, 58, p 257-267.

³² Australian Institute of Public Welfare, 2013, *Palliative care services in Australia 2013*, accessed <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129545131>, p 65.

³³ Ganzini, L. et al., p 560.

3.1 PALLIATIVE CARE: EDUCATION

Cabrini Health notes:

Many people fear the term “palliative care”, believing it is only about dying. It is true that palliative care is for people who have an illness for which there is no cure, but the primary role of palliative care is to support patients, as well as their families, in living with their illness.³⁴

We encourage programs that educate the broader community about the purpose and availability of palliative care. We have identified the following as particular issues that need to be addressed:

- **The right to refuse treatment:** Responsible and respectful palliative care is not about extending life at all costs. The medical “duty to preserve life” must be balanced with the fact of death and the patient’s autonomy.³⁵ Patients must be made aware of their rights under the *Medical Treatment Act* to refuse overly burdensome treatment.³⁶
- **Identifying overly-burdensome and futile treatment:** There can be confusion among patients and health care professionals as to what constitutes overly-burdensome and futile treatment. These terms depend on the patient’s condition, age, disposition and range of other factors. We strongly encourage education and professional development for health care workers to identify when treatment is futile, so that patients and their families are given appropriate information and care for their state of life.
- **Cure and comfort—when the need for palliative care begins:** The line between treatment for cure and comfort (palliative care) is not simply a sharp delineation. They can occur at the same time, for example, a cancer patient may be undergoing cure-focussed therapy, such as chemo-radiation, while still accessing palliative care. We encourage training and education for health care professionals to identify when palliative care should begin in a patient’s treatment.
- **Increasing confidence:** Underlying requests for euthanasia are the expression of different fears; fear of death, pain, loneliness, being a burden and countless others. We must address these fears at their roots and provide timely, holistic and community support.

³⁴ Cabrini Health Care, accessed <http://www.cabrini.com.au/patients-and-families/services/directory/palliative-care>

³⁵ Tobin, B, 2008, ‘More Talk, Less Paper! Why health care proxies are a better means of extending traditional morality than are living wills’, *Bioethics Outlook*, vol 19(3), September, p 1.

³⁶ Under the *Medical Treatment Act* 1988 (Vic) 5B, accessed http://www.austlii.edu.au/au/legis/vic/consol_act/mta1988168/

There is much great work done in developments and research in palliative care. We need to spread this positive news so that people can approach end of life care with confidence.

4. ADVANCE CARE PLANNING

An ageing population³⁷ coupled with increased life expectancy means many people will die having lost or limited decision making capacity. For this reason, advance care planning is a vital part of end of life care. It has been shown to reduce stress, anxiety and depression in surviving loved ones.³⁸

Plans can take the form of an informal discussion with family, friends, or the health care professional or be a formalised process with the appointment of a health care proxy or written advance care directive.

The *Palliative Care* report found that plans were not being implemented effectively within institutions.³⁹ Previously, in 2012, the Victorian Law Reform Commission (VLRC) made three suggestions in order to improve the use of plans; that directives be made legally binding, that the *Medical Treatment Act's 1998* (Vic) refusing treatment clause change from "current conditions only" to allow patients to refuse care for future conditions and that new offences be created for people who do not comply with the directions in a plan.⁴⁰

While this seems to be a positive step in the direction of patient autonomy, there are several consequences of making legally binding directives for a future condition which would not only limit patient autonomy, but could have dangerous effects on health care.

4.1 CONCERNS WITH LEGALLY BINDING DIRECTIVES

- **Inadequately informed consent:** The progress of illness is often unpredictable and it is unlikely that the patient will have enough information on a *future* health condition to give fully informed consent in advance.⁴¹ It is also inflexible in its understanding of informed consent. The ability to make an informed decision is not static. It is dynamic

³⁷ Australian Bureau of Statistics, 2013, 'Population Projections Australia, 2012 to 2101', accessed [http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/3222.0main+features52012%20\(base\)%20to%202101](http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/3222.0main+features52012%20(base)%20to%202101)

³⁸ Department of Health and Human Services, 2014, 'Advance care planning - have the conversation: A strategy for Victorian health services 2014-2018', accessed [http://betterhealth.vic.gov.au/bhcv2/bhcrecnews.nsf/doc/11AAC3B4CA08709DCA257D55000A7560/\\$FILE/Advance%20Care%20Planning%20-%20Strategy.pdf](http://betterhealth.vic.gov.au/bhcv2/bhcrecnews.nsf/doc/11AAC3B4CA08709DCA257D55000A7560/$FILE/Advance%20Care%20Planning%20-%20Strategy.pdf), p 13.

³⁹ Victorian Auditor General, p 28-32.

⁴⁰ Victorian Law Reform Commission, 2012, *Guardianship: Final Report*, Recommendations 135, 139, 140 and 152, accessed http://www.lawreform.vic.gov.au/sites/default/files/Guardianship_FinalReport_Ch%2011_Documenting%20wishes.pdf.

⁴¹ Fagerlin, A., and Schneider, C.E., 2014, 'Enough: The Failure of the Living Will', *The Hastings Center Report*, March/April; 34, 2, p 30-42, accessed <http://search.proquest.com.ezproxy.slv.vic.gov.au/health/docview/222397243/fulltextPDF/347A5680DE424A84PQ/6?accountid=13905>.

and continuous. For example, a patient with dementia may not have decision making capacity in the morning but have it in the afternoon.

- **Inflexible to changing circumstances:** A stand-alone form could not be detailed or nuanced enough to account for every eventuality during the course of an illness.⁴² A legally binding directive may not account for:
 - improvements in technology
 - changes of mind
 - improvements in illness
 - extraordinary circumstances
 - other life changes such as a change in finances or family situations.
- **Limits choice:** Patient choices are limited by the structure and wording of the form. For example, the Advance Care document in the Respecting Choices Program, put forward by Austin Health, frames the questions as follows: “I would like life prolonging treatment if ...” This structure limits patient choices to physical outcomes only and assumes a static frame of mind. For example, a young, healthy person may determine that losing speech after a stroke is unacceptable, and direct to have their support discontinued. However, this neglects the common experience of people learning to accept and live within the limitations of a disability. In effect, a past decision will be given priority over a better informed future decision.
- **Disadvantage to groups with limited literacy:** Limiting the patient’s health care solely on a written directive may be disadvantageous to groups with limited literacy, such as migrant and refugee communities, who would not be best able to express themselves in writing. The Catholic Church works extensively with migrant and refugee communities and we see how these could be disadvantaged. A patient’s wishes would be best represented by ongoing communication between patient, doctor and their community of family and other supporters.
- **Freedom of conscience:** A written instruction on a directive may insist that a doctor acts in a way that is not, in their professional and informed opinion, in the best interest of the patient. This may disregard the doctor’s rights under section 14 of the *Charter of Human Rights and Responsibilities Act 2006* (Charter),⁴³ which protects an individual’s freedom of conscience, religion and belief. Upholding a person’s freedom and autonomy should never be obtained at the expense of another person’s freedom of conscience.

⁴² Tonti-Filippini, N., 2011, ‘To Love...Until the End: Who will Make Your Choices?’, delivered at St Gregory the Great Hall, Doncaster, Thursday 29 November.

⁴³ *Charter of Human Rights and Responsibilities Act 2006* (Charter) 14, accessed [http://www.legislation.vic.gov.au/domino/web_notes/ldms/pubstatbook.nsf/f932b66241ecf1b7ca256e92000e23be/54d73763ef9dca36ca2571b6002428b0/\\$file/06-043a.pdf](http://www.legislation.vic.gov.au/domino/web_notes/ldms/pubstatbook.nsf/f932b66241ecf1b7ca256e92000e23be/54d73763ef9dca36ca2571b6002428b0/$file/06-043a.pdf)

- **Possible deterrent:** The healthcare proxy is an important component in best practice advance care. Possible legal ramifications could deter people from volunteering for this important position. We encourage ways to create a supportive, encouraging and non-threatening environment for people taking on this responsibility.

Any changes to legislation around advance care planning must reflect the dynamic nature of choice, decision making capability and terminally illness. Given the inflexible nature of a prescriptive document, we suggest that any advanced care plans be *descriptive* rather than *prescriptive* and not be legally binding.

4.2 ADVANCE CARE PLANNING – A BETTER WAY

The Australian Catholic Bishops Conference (ACBC), in conjunction with Catholic Health Australia (CHA), has released a 'Guide for considering their future health care'. Patients are able to nominate a proxy or representative in the case of ill health, as well as write a written statement of their preferences. In the form, patients are asked:

- When I am ill and unable to make my own decisions, the following would be important to me ...
- In addition to basic care, the following would be important to me ...
- Treatments I wouldn't want ...
- Religious and spiritual care ...
- Other wishes ... ⁴⁴

The form is *descriptive* rather than *prescriptive*. This gives the health professional a sense of who the person is—their values, goals and outcomes for health—in a way that provides flexibility in changing circumstances.

More information can be accessed at the My Future Care website at <http://myfuturecare.org.au/>.

Another important aspect to improving advance care planning is facilitating end of life conversations. A 2013 study conducted by Monash University and Alfred Hospital found that 64 per cent of patient charts record that the first end of life discussions occurred in the last 24 hours of life.⁴⁵ Another study found that only 66 per cent of health professionals had a level of comfort dealing with discussions around advance care plans and 76 per cent

⁴⁴ Australian Catholic Bishops Conference and Catholic Health Australia, 'Guide for people considering their future health care', accessed [https://www.sydneycatholic.org/works/pdf/A%20guide%20for%20people%20considering%20their%20future%20health%20care%20\(Comprehensive%20version\).pdf](https://www.sydneycatholic.org/works/pdf/A%20guide%20for%20people%20considering%20their%20future%20health%20care%20(Comprehensive%20version).pdf)

⁴⁵ Victorian Auditor General, p 29.

reported having very few or no conversations with patients in the last six months.⁴⁶ These conversations need to take place much earlier in the treatment process. In their award winning “Raise the Bar” initiative, Villa Maria Catholic Homes identified four key moments when these conversations should take place. These are:

- pre-admission
- admission
- when a significant event changes the resident’s condition
- end of life pathway

Villa Maria Catholic Homes has implemented ongoing conversations around these four moments across their 15 facilities.

We support any initiatives to assist clinicians and health care providers raise the topic of end of life care and death with patients.

5 CONCLUSION

We would be happy to expand on any of these observations and recommendations if that would be of assistance to the Committee.

We would also welcome the opportunity to appear at the hearings and are available to provide any further information or clarification the Committee would find helpful.

⁴⁶ Silvester, W. 2012, ‘Quality of advance care planning policy and practice in residential aged care facilities in Australia’, *BMJ Supportive and Palliative Care*.

OUTCOME OF EUTHANASIA BILLS PRESENTED IN AUSTRALIAN PARLIAMENTS

1995 TO 2015

Year	Parliament	House	Title	Outcome
1995	NT	Legislative Assembly	Rights of the Terminally Ill Bill	Passed on 25 May 1995. Repealed by Euthanasia Laws Act 1997 (Cth) on 27 March 1997
	SA	House of Assembly	Voluntary Euthanasia Bill	Rejected on 27 July 1995 30 votes to 12
	ACT	Legislative Assembly	Medical Treatment (Amendment) Bill	Rejected on 22 November 1995 10 votes to 7
1996	SA	Legislative Council	Voluntary Euthanasia Bill	Referred to Social Development Committee which reported on 20 October 1999 and recommended that active voluntary euthanasia and physician assisted suicide remain criminal offences and that the lapsed 1996 Bill not be introduced.
1997	WA	Legislative Council	Voluntary Euthanasia Bill	Second Reading Speech 16 October 1997
	ACT	Legislative Assembly	Euthanasia Referendum Bill	Rejected 5 November 1997 15 votes to 2
1998	WA	Legislative Council	Voluntary Euthanasia Bill	Second Reading Speech 20 August 1998
2000	SA	Legislative Council	Dignity in Dying Bill	Lapsed due to Prorogation
	WA	Legislative Council	Voluntary Euthanasia Bill	Second Reading Speech 10 May 2000
	WA	Legislative Council	Voluntary Euthanasia Bill	Second Reading Speech 19 October 2000
2001	NSW	Legislative Council	Rights of the Terminally Ill Bill	Rejected on 21 March 2002 26 votes to 9
2002	SA	Legislative Council	Dignity in Dying Bill	Lapsed due to Prorogation
	WA	Legislative Council	Voluntary Euthanasia Bill	Lapsed 23 January 2005
	SA	House of Assembly	Dignity in Dying Bill	Lapsed due to Prorogation
2003	NSW	Legislative Council	Voluntary Euthanasia Trial (Referendum) Bill	Rejected on 13 November 2003 28 votes to 4
2005	SA	House of Assembly	Dignity in Dying Bill	Lapsed
2006	SA	House of Assembly	Voluntary Euthanasia Bill	Lapsed
2007	SA	House of Assembly	Voluntary Euthanasia Bill	Lapsed

2008	SA	House of Assembly	Voluntary Euthanasia Bill	Lapsed	
	SA	Legislative Council	Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill	Negated 24 November 2010	
	VIC	Legislative Council	Medical Treatment (Physician Assisted Dying) Bill	Defeated on 10 September 2008 25 votes to 13	
2009	TAS	Legislative Assembly	Dying with Dignity Bill	Second Reading Speech 4 November 2009	
2010	SA	House of Assembly	Voluntary Euthanasia Bill	Lapsed	
	SA	House of Assembly	Criminal Law Consolidation (Medical Defences End of Life Arrangements) Amendment Bill	Lapsed	
	WA	Legislative Council	Voluntary Euthanasia Bill	Rejected on 22 September 2010 24 to 11 votes	
2011	SA	House of Assembly	Criminal Law Consolidation (Medical Defences End of Life Arrangements) Amendment Bill	Lapsed	
2012	SA	House of Assembly	Voluntary Euthanasia Bill	Rejected 14 June 2012 22 to 20 votes	
2013	NSW	Legislative Council	Rights of the Terminally Ill Bill	Rejected on 23 May 2013 23 votes to 13	
	TAS	Legislative Assembly	Voluntary Assisted Dying Bill	Rejected on 17 October 2013 13 votes to 11	
	SA	House of Assembly	Ending Life With Dignity Bill	Lapsed	
2014	CTH	Senate	Medical Services (Dying with Dignity) Exposure Draft Bill	Referred to the Legal and Constitutional Affairs Legislation Committee on 24 June 2014 which reported on 10 November 2014	