

**Rerum Novarum Oration**  
***Widening The Door of Hope***  
**20 November 2018**  
**Mercy Lecture Theatre,**  
**Australia Catholic University, Fitzroy**  
**Dr Stephen Parnis**

Thank you, for that kind introduction.

I wish to also acknowledge the Wurrundjeri People as the traditional custodians of this land, and to pay my respect to their elders.

I'm honoured to be speaking alongside my colleague Natasha tonight, as Victoria comes to terms with the fact that it will soon be legal for assisted suicide or euthanasia to be administered to certain individuals.

I am mindful of the landmark Letter Entitled "Rerum Novarum", also known as the "Rights and Duties of Capital and Labour".

I first came to know about Rerum Novarum when I was at university, and I was struck by the importance of the protection of the vulnerable, in that case the right of workers to form industrial unions in order to resist those who would seek to exploit them for personal gain. I also noted the fact that the letter sought to

balance the legitimate rights of individuals, with the responsibility to act in the common good.

Both of these themes – protection of the vulnerable, and balancing individual autonomy against the common good – are front and centre in the ongoing debate about end of life care being held in this state, across this nation, and around some parts of the developed world.

The fact is, that twelve months ago, the Victorian Parliament narrowly passed a law which established legal circumstances for assisted suicide and euthanasia. Mechanisms are now being put in place to enable that law to take effect from 19 June next year. I argued then that it was deeply flawed, and I don't resile from that position for one moment.

The obvious question which must be asked, is "Where to from here?"

And it needs to be asked by each and every one of us, by doctors, nurses and health professionals, and by every institution which cares for the sick, such as hospitals, nursing homes and hospices.

I say, that the answers to that question lie in three key areas.

One is gaining a better understanding of what it means to be dying – what I call death literacy, and others might call facing the reality that we and those we love are mortal.

Two is in subjecting these new Victorian laws to the greatest possible scrutiny, and in continuing to resist the attempts being made elsewhere to have assisted suicide and euthanasia made legal.

Three is, ultimately, to render these laws redundant. I believe that can be done if a concerted effort is made to practice end of life care in the way it always should be practiced – with knowledge & confidence, appropriate resources and undoubted expertise.

I now turn to death literacy.

When I was elected State President of the Australian Medical Association in 2012, I stated that my highest priority was to improve the provision of End of Life Care. That was, and remains, a monumental task, requiring years of concerted effort by government, the health professions and the entire community. It essentially asks for a significant cultural shift in the way

many Australians view the end of their own lives, and those of their loved ones.

Why did I make this my highest priority? Put simply, it's because I think Australians have generally been seduced by the notion that medical technology and expertise is the ticket to a fully independent life of one hundred years, followed by an instantaneous death, akin to turning off an electrical switch.

I think we have progressively become more and more quarantined from the realities of death in recent decades – most Australians die in hospital, and while 80% of Australians think that discussion about their end of life needs is important, less than a quarter have actually done so.

Only recently, I attended the funeral of a member of my extended family, where I noted a real reluctance by anyone to enter the church, because of the presence of the casket. At another funeral, I and my children (with my encouragement) were the only ones wanting to touch the dead body of my late uncle, which I encouraged as a way of saying goodbye and giving thanks in a loving way for all the things we shared.

I use these examples from my own family to make a point. Fear of death and dying, of the unknown, of a loss of control, and dependence on others – are powerful, emotive drivers of behaviour.

Under the influence of that sort of fear and denial, it is easier to put one's hope in a magic pill that makes a dubious promise of quick, painless death, where one is said never to become a burden on others. The desperation to believe all these unfounded guarantees trumps any concern about the risks of wrongful death for thousands of others, of abuse of process, and gives no respect to the lost opportunity for time to reflect, love and be with another human being who may be hours or even years away from their death.

Death literacy is all about the empowerment of a person, and their loved ones, to help them anticipate what is to come, to respect their preferences and priorities, and to reassure them that the things that bring fear to many of us in the dark of night – pain, isolation and despair – can be replaced with comfort, compassion and – to use the word seemingly monopolised by my opponents – dignity.

Over the last few years, there have been many moves in the right direction relating to End of Life Care. Informal discussions about death and dying within

families, between patients and GPs, and among many social and cultural groups are increasing. In Victoria only six months ago, laws came into effect which encourage and enable a healthier approach to end of life care in the form of Advance Care Directives and Substitute Decision Makers.

These initiatives are most welcome, but they have not been given enough time to become embedded in the community. And they have not been accompanied by enhancement of the palliative care sector. In fact, I contend that the overwhelming focus on the divisive issues of assisted suicide and euthanasia, has drained attention and resourcing away from where it should have gone: palliative care. And palliative care, when it is truly understood, is a concept which seems to enjoy almost universal support. To those who have argued for assisted suicide on the grounds of providing choice, I say this: there is little or no choice between suicide or palliative care, when the availability of palliative care is often threadbare, and even less available to those without a tertiary degree and an affluent postcode.

I now turn to subjecting the Victorian laws to scrutiny, and fighting the battle elsewhere.

The principal argument against assisted suicide and euthanasia laws is that you cannot make them safe. I said last year that I think you can drive a truck through the so called “safeguards” in the Victorian legislation, and I genuinely hope that time proves me wrong. Usually, when bad legislation is framed, the effect is a waste of money, a delay in service provision, or the imposition of a burden upon part or all of the community.

In this case, the so-called “Voluntary Assisted Dying Act 2017” has the capacity to result in wrongful deaths, and many of them. In the public debate, and then the parliamentary debate, all sorts of guarantees were offered – that all deaths would be voluntary, that death would be quick and painless, that nobody else would be placed at risk, that only those with months or less to live would be eligible, that other types of suicide would decline, that informed consent was inescapable, and that the criteria for eligibility would not expand.

It falls to us now to use the tools at our disposal to hold the system and its proponents to account. In an era of unprecedented scrutiny of medical practice, it will require determination to shine light on this area – to hold this system of assisted suicide and euthanasia to account, via the Voluntary Assisted Dying Review

Board, the Medical Board of Australia, the State Coroner, the Department of Health and Human Services, and via the Parliament of Victoria.

Many necessary questions will be difficult to answer, such as accuracy of diagnosis and prognosis, the effectiveness of the lethal drugs, and whether informed consent was really obtained. But we must take this path.

I assert that here in Victoria, we must carefully understand and vigorously defend the place of conscientious objection.

There must be no victimisation of the doctors, nurses and institutions that refuse to participate in assisted suicide. And I remind all my colleagues that refusal to participate in this process must never equate to the denial of care to those who disagree with us. We must still walk the journey with our patients.

Through last year's political debate, and to some extent even now, some proponents of Assisted Suicide sought to personally attack, marginalise and discredit myself and my colleagues. Having spent over a decade speaking publicly on matters of ethics on behalf of the medical profession, it was a new experience to be labelled a religious zealot by my opponents, and more a case of the pot calling the kettle black.

In the aftermath of the Victorian debate, efforts have been redoubled elsewhere to legalise assisted suicide and euthanasia. Proponents have sought to build momentum, and use the template developed in Victoria – a parliamentary committee, an advisory panel to frame legislation and build a case, then a short sharp parliamentary debate.

It is tempting for some to think the battle is over, but I can tell you it is not.

In the Federal Parliament in August, an attempt to remove the twenty year prohibition on Territory laws favouring euthanasia/assisted suicide was defeated, despite a strong push to associate the issue with Territory rights. To me, it was yet another attempt to confuse and distract MPs away from the main issue of end of life care. I thank the Senate for its courage in standing up for the vulnerable.

Now the debate has moved to Western Australia and to Queensland, and the rules have changed. No longer are private members bills the order of the day. They are government sponsored bills. In the aftermath of the Victorian debate, I am encouraged by the establishment and effectiveness of lobby groups such

as the Australian Care Alliance, which seeks to answer the previously uncontested assertions of well resourced groups pursuing assisted suicide. We will not shy away from making the case for an end of life care system of which we can all be proud.

Finally, I wish to speak about caring for Australians in such a way as to render Assisted Suicide and Euthanasia unnecessary. As I mentioned earlier, this goal is ambitious, but absolutely achievable if the determination is there.

The principles of universal access and expert care are not new to the Australian health system. Medicare has been in place since 1984, and I am proud to live and practice medicine in a nation where the first question I always get to ask a patient is “How can I help you?”, and not to ask myself whether they have the means to afford the care they need.

In the same way, palliative care must be enhanced at many levels to enable universal access and care on the basis of need rather than means. The evidence clearly shows that patients are not referred to palliative care early enough. There is inadequate recognition that palliative care should occur in parallel with curative

care. There needs to be a greater recognition of the place for palliative care skills across the medical profession, and the need for greater numbers of trainees and specialists in hospital and community based palliative care. The eternal cost-shifting between state and federal governments over health funding, which includes palliative care, needs to change to enable better care for dying patients, when and where they need it.

And we must never forget, that we have to care for the family and friends of the dying patient. They too feel vulnerable and powerless, may not understand what their loved one needs, or worse, understand and yet be unable to provide exactly what their loved one needs!

And so, I am back to where I began in 2012. I believe we can and must do better in the way we care for our loved ones, patients and ourselves near the end of our lives. And that can be achieved by improving our understanding, expertise and service delivery in the realm of palliative care. It will never be achieved by providing the means to patients to simply kill themselves.

As a doctor, I have the expertise to relieve suffering, to provide care and compassion, and thus enable a good death. I have an obligation to provide the best possible

care, and to walk with my patients and their loved ones. I am not a vending machine.

I close with a quote from Senator Pat Dodson, in his contribution to the Senate debate in August:

“If we give one person the right to make that decision – that is, to assist in committing suicide – we as a whole are affected. If we give one family that right, we as a whole are affected. If we give one state or territory that right, we as a country are affected. If we give one nation the right to determine life, our common humanity is affected.”

Thank you.