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To Health and Environment Committee

RE: Voluntary Assisted Dying Bill submission

I am a thoracic physician with 28 years experience caring for patients with a range of severe lung diseases in Brisbane. I am in full time private practice and also work one day per week in the public health system. I have had the privilege of caring for many patients throughout a journey, which starts with diagnosis of their condition, leads to treatments with uncertain outcome, and ends in their death. I was present at my father's death, and my daughter has a severe intellectual disability, so I am both professionally and personally engaged by this issue.

I am yet to find a patient where the current approach has truly failed the patient and their family, provided there is adequate resourcing for palliative care. Unfortunately, there are sometimes limitations of palliative care which lead to very adverse patient and family experiences. The response to improve the experience of suffering before death should primarily be to increase access to better resourced palliative care. Increased funding for palliative care is a step in the right direction. The Voluntary Assisted Dying (VAD) legislation is a dangerous step in the wrong direction.

VAD is a simplistic and fear-driven solution which will have unintended major consequences for many patients, and society as a whole.

Damage to the trust in the doctor-patient relationship

Having a legislated VAD option will change the relationship between the treating physician and the patient. This will have negative ramifications for society as a whole, and how patients view their place in society at a particularly difficult period.

It is common for a patient diagnosed with an advanced lung disease with expected survival of less than a few years to discuss euthanasia. Most often, this is the patient's way of saying that they fear that they will be a burden to family members, or that they fear severe distress before they die. With

our current legal framework, this question can be addressed in a fairly straightforward and empathetic way. I explain that my goal is to relieve as much distress as possible, but that there may be some discomfort along their journey which I will work hard to relieve. I try to relieve their fears that they will be a burden on society. As patients start to appreciate the possible solutions, their fears of being a burden or excessive suffering usually diminish. At the end of these discussions, the patient recognises that I am a partner with them on a difficult journey. They perceive that they can be completely honest with me. If a patient develops severe distress and has limited survival despite my best efforts to treat their disease, we discuss options to withdraw burdensome treatments that are prolonging life and therefore suffering. We also progressively increase the dose of pain relieving medications until severe symptoms are relieved, and we continue to increase the dose of these medications until distress is relieved, even if those medications shorten life. These ways to avoid excessive suffering and unnecessary prolongation of life are all supported by the current legal framework, and do not require VAD legislation to be introduced. If VAD legislation is introduced, we can no longer have the same honest, trusting relationship with an easily shared common objective, to work together to achieve the best life possible in difficult circumstances, including doing everything possible to minimise distress. VAD would produce extra anxiety and insecurity into a challenging area. I do not believe any safeguards can adequately prevent negative impacts of VAD legislation on the physician-patient relationship, because it produces a fundamental change in the traditional approach. In case you think I am a lone voice, please check the position of any major medical association.

Competency of patients to make a decision about VAD should have specialist assessment where possible

With many serious illnesses, patients commonly have fluctuating mood or mental ability which reduces their ability to make a sound decision about other aspects of their health. Given the irreversible nature of a VAD decision, it is noted that there is no provision for medically specialised assessment of a patient's capacity to make such a decision (in locations where that is able to be accessed in reasonable geographic proximity). It is expected that some patients will have subtle depression or cognitive impairment when they ask for VAD, and a different decision would likely have been made if that was identified by specialised assessment.

Time frame for expected survival of 12 months should be 6 months or less

Experienced doctors know that it is very difficult to accurately estimate expected survival, and that specialist assessment of survival is likely to be more accurate (but still only a best estimate). It is

common that expected survival may be thought to be less than 12 months, but actual survival may be years, or even lead to full recovery. Estimating survival is less accurate earlier in the illness. For most medical illnesses, more severe symptoms tend to develop in the last weeks or few months of life. It is therefore strongly recommended that the bill modify the expected survival to be less than 6 months. It is also strongly recommended that specialist assessment of prognosis be considered wherever this can be readily accessed.

VAD will introduce an economic driver to move away from good quality palliative care and will consequently increase distress and suffering

There is a misplaced portrayal that the VAD bill is a compassionate option. It will introduce anxiety and will be an additional source of confusion for patients and their families. Most patients will not choose VAD because patients and their families usually prefer to live as best as they possibly can, and realise the uncertainty in predicting survival and future distress. In promoting VAD through this bill, as an alternative to good palliative care, the limitations and cost of good palliative care in Queensland are not considered, nor the implications of VAD on future funding of palliative care. Well-resourced and accessible palliative care would allow a good death for most patients and their families. Unfortunately we are a long way from well-resourced palliative care, especially in rural areas. By allowing VAD, you will introduce a subtle pressure to accept VAD (instead of woefully inadequate palliative care in some areas, with associated marked suffering). Introducing VAD will end up undermining better resourcing of palliative care, especially in rural areas where palliative care is more difficult.

Thank you for taking the time to read this letter.

Yours sincerely,



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