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23 March 2018

Secretary  
Select Committee on End of Life Choices in the ACT  
Legislative Assembly for the ACT  
GPO Box 1020  
CANBERRA  
ACT 2601

Dear Committee

***Re: Submission to the Select Committee on End of Life Choices in the ACT***

The Australian Christian Lobby (ACL) welcomes the opportunity to provide a submission to the Select Committee considering end of life choices in the ACT.

ACL's vision is to see Christian principles and ethics influencing the way we are governed, do business, and relate to each other as a community. ACL seeks to see a compassionate, just and moral society through having the public contributions of the Christian faith reflected in the political life of the nation.

With more than 100,000 supporters, ACL facilitates professional engagement and dialogue between the Christian constituency and government, allowing the voice of Christians to be heard in the public square. ACL is neither party-partisan nor denominationally aligned. ACL representatives bring a Christian perspective to policy makers in Federal, State and Territory Parliaments.

Please feel free to contact me if I can be of further assistance in the consideration of this matter. I would be pleased to meet to discuss our submission or any other aspect in respect to this review.

Yours sincerely,

***Martyn Iles***  
***Managing Director***

## ACL Submission Concerning End-of-Life Choices in the ACT

Advocates for euthanasia point to cases in which suicide is entirely consistent with the express wishes of the individuals concerned and whose capacity to exercise autonomy in decision-making is considerable. According to Professor Diane Meier, professor of Geriatrics in New York “the movement to legalise euthanasia is driven by the ‘worried well,’ by people who are terrified of the unknown and want to take back control.”<sup>1</sup> It is argued that existing laws which prohibit private citizens acting to bring about the death of others should be relaxed to facilitate the express wishes of some people to choose the time and manner of their own death.

Clearly laws to facilitate the voluntary suicide of some individuals in limited circumstances also need to anticipate the effect of such a relaxation on the often less-than-ideal circumstances in which these laws will be applied. Can the government ensure that allowing euthanasia in some cases will not lead to the death of individuals who would not otherwise have chosen to be killed? The possibility of the ‘involuntary euthanasia’ of some citizens must be weighed against the benefits of expanding the range of end-of-life choices for the wealthy, white, worried well advocates for voluntary assisted dying.

This submission canvasses the compelling arguments against the legalisation of euthanasia that have emerged both in Australian debate and internationally, and suggests the present inquiry focus particularly on alleviating the suffering of those with terminal illness by more compassionate means than simply hastening their death.

### Euthanasia is only possible when we agree that some lives are not worth living

Legalising euthanasia requires more than a simple change to the law. It represents a paradigm shift from an ethical and legal framework that declares the deliberate taking of life by private citizens (including medical professionals) as morally insupportable in absolute terms to one which allows relative and circumstantial evaluations to be made about different lives on a case-by-case basis. Euthanasia can only be contemplated by putting aside the current legal recognition of the unique and infinite value of the human person, to instead embrace the acknowledgment that some lives are not worth living.

### The trajectory of euthanasia law overseas demonstrates the normalisation of suicide

If the boundary is thus shifted from an absolute prohibition against assisted dying to partial one, unassailable logic is needed to support the revised boundary firmly in its new place; in this case, to clearly differentiate when the deliberate taking of life is criminally culpable and when it represents compassion. Wherever the new line is drawn with regard to age, illness, pain levels or types of suffering, it would be unreasonable to expect that these will not be challenged by individuals with suicidal ideation who fall outside them. For example, if certain diagnosis of terminal illness within 6 or 12 months is agreed as the necessary prerequisite before euthanasia can be considered, it is reasonable to anticipate that those whose death is more remotely anticipated will challenge this. Questions will then arise that require an answer:

- Who can anticipate the predicted time of death accurately?

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<sup>1</sup> Rachel Aviv, “The Death Treatment: when should people with a non-terminal illness be helped to die?”, *The New Yorker*, 22 June 2015. Available here: <https://www.newyorker.com/magazine/2015/06/22/the-death-treatment>

- Does the illness need to be terminal? What proofs do we require about this?
- Does euthanasia need only to concern the elderly? If not, what age limits should apply? If we allow autonomy for the elderly, why not for those who are younger? At what age can someone be allowed to decide to die?
- Should those with ‘unendurable’ pain from untreatable, but not terminal, conditions be excluded?
- Why restrict assisted suicide to physical suffering; why not existential suffering, such as depression or mental illness that causes excruciating pain that cannot be alleviated? Since psychiatry is still a developing science, how can we tell if a mental illness is untreatable?
- Many people with suicidal ideation are depressed. How do you then distinguish between those cases of depression that are, indeed, hopeless and those that may respond to treatment?
- If everyone has the right to individual autonomy, how can anyone else tell them when they can and cannot die? What authority does anyone else have to interfere?

Challenges of this type in overseas experience have seen fears of ‘the slippery slope’ realised, as initially conservative parameters around euthanasia have yielded to pressure for their expansion.

### Belgium

A 2012 Belgian report reviewing the national situation a decade after euthanasia had first been legalised, expressed concern about how euthanasia was increasingly regarded as a trivial matter:<sup>2</sup>

*Initially legalized under very strict conditions, euthanasia has gradually become a very normal and even ordinary act to which patients are deemed “to have a right”.*<sup>3</sup>

Belgium legalised euthanasia in 2002 for patients with constant and unbearable physical or mental suffering that could not be alleviated. In the early years, euthanasia for psychiatric patients was uncommon and this ‘treatment’ was reserved mostly for terminally ill cancer patients. However, “psychiatric patients complained that they were being unfairly stigmatized: psychic suffering, they argued, was just as unbearable as physical pain. Like cancer patients, they were subjected to futile treatments that diminished their quality of life.”<sup>4</sup>

Cases that have challenged the ethical basis of euthanasia include Professor De Wachter’s approval of the euthanasia of a 25-year-old woman with borderline personality disorder who did not “suffer from depression in the psychiatric sense of the word ... It was more existential; it was impossible for her to have a goal in this life.” Her parents “came to my office, got on their knees, and begged me, ‘Please, help our daughter to die.’”<sup>5</sup>

The case of Godelieve De Troyer, who was euthanised at the age of 64 for “untreatable depression” has now been referred for a second time to the European Court of Human Rights.<sup>6</sup> De Troyer chose

<sup>2</sup> *Euthanasia in Belgium: 10 years on*, European Institute of Bioethics, April 2012, p. 8 (Available at: <http://www.ieb-eib.org/fr/pdf/20121208-dossier-euthanasia-in-belgium-10-years.pdf>).

<sup>3</sup> Op. cit. p. 7.

<sup>4</sup> Rachel Aviv, op. cit.

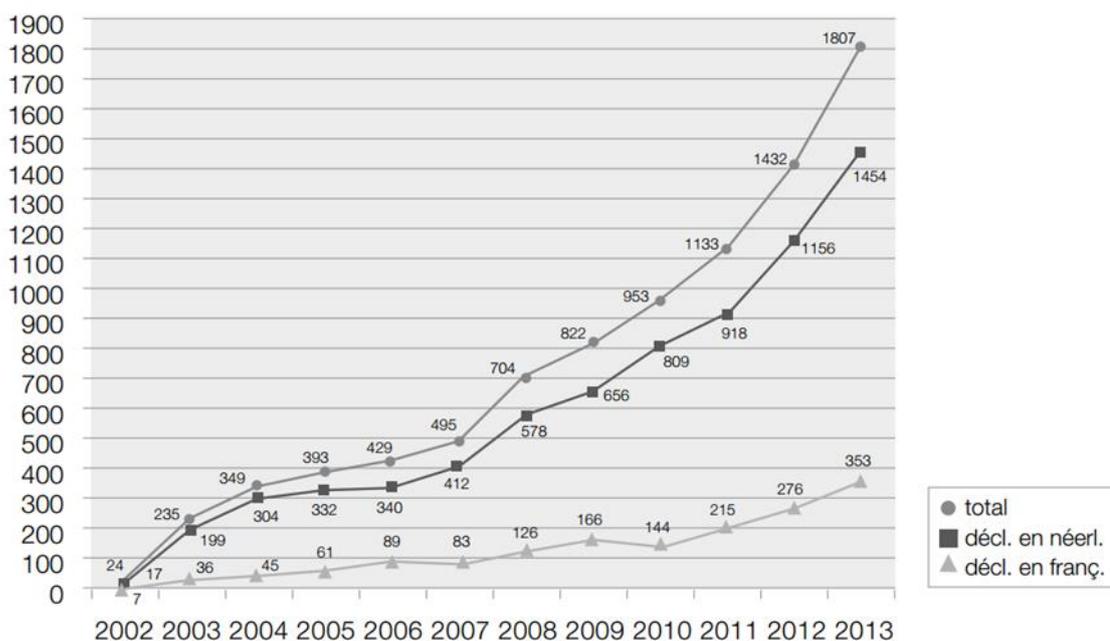
<sup>5</sup> Rachel Aviv, op. cit.

<sup>6</sup> The internal investigation is heavily compromised by the fact that Dr Distelmans also chairs Belgium’s Federal Control and Evaluation Committee on Euthanasia, files were lost, a statement from the third doctor required by law to approve De

to end her life by lethal injection at her own request in a Brussels hospital in April 2012. Her son, Tom Mortier, alleges that at least two of the experts who assessed De Troyer did not agree that her depressive illness was beyond treatment.<sup>7</sup> He has accused Dr Wim Dilstelmans, the humanist doctor whose organisation had been supervising the treatment of his mother's depression and who eventually approved her euthanasia (after she had made a donation of EUR2,500 to his organisation) of "going along with her madness".<sup>8</sup>

The numbers of Belgian deaths by euthanasia have been steadily increasing, rising by 250% in the 5-year period between 2008 and 2013 alone.<sup>9</sup>

### Evolution du nombre annuel d'euthanasies légales



Though euthanasia for children was canvassed in the initial debates preceding legalisation in Belgium, this was initially rejected due to strong political opposition. Twelve years later, in 2014, Belgian euthanasia laws were extended to allow lethal injections for terminally ill children of any age.<sup>10</sup> The

Troyer's euthanasia was missing. Having been referred to the European court, the case was rejected on the basis that internal remedies had not been exhausted. Apparently in the face of insufficient will on the part of Belgian authorities to investigate, the case has now been referred back to the European Court of Human Rights. (See case notes submitted to the European Court of Human Rights here: <https://adflegal.blob.core.windows.net/international-content/docs/default-source/default-document-library/resources/media-resources/europe/mortier-v-belgium.pdf>).

<sup>7</sup> Bruno Waterfield, "Son challenges Belgian law after mother's 'mercy killing'", *The Telegraph*, 2 February 2015. Available at: <http://www.telegraph.co.uk/news/worldnews/europe/belgium/11382843/Son-challenges-Belgian-law-after-mothers-mercy-killing.html>

<sup>8</sup> *Mortier v. Belgium*, Alliance Defending Freedom, 15 June 2015. (Available at: <http://www.adfmedia.org/News/PRDetail/9672>).

<sup>9</sup> Commission Fédérale de Contrôle et D'évaluation de L'euthanasie Sixieme Rapport Aus Chambres Législatives (Années 2012–2013) [http://organesdeconcertation.sante.belgique.be/sites/default/files/documents/federale\\_controle\\_en\\_evaluatiecommissie\\_euthanasie-fr/19097638\\_fr.pdf](http://organesdeconcertation.sante.belgique.be/sites/default/files/documents/federale_controle_en_evaluatiecommissie_euthanasie-fr/19097638_fr.pdf)

<sup>10</sup> Robert-Jan Bartunek, "Belgium allows euthanasia for terminally ill children", *Sydney Morning Herald*, 14<sup>th</sup> February, 2014. Available at: <http://www.smh.com.au/world/belgium-allows-euthanasia-for-terminally-ill-children-20140214-hvcb9.html>.

normalisation of euthanasia in Belgium and consequent relaxation of the initially strict requirements is further illustrated to a couple of recent high-profile the cases. One involved 45-year-old twins, Marc and Eddy Verbessem who were born deaf. When they were told they were also going blind, they believed they had nothing left to live for and chose euthanasia.<sup>11</sup> Another concerns a 44-year-old transsexual woman whose botched sex-change operation left her with physical deformities that she felt made her look like a "monster".<sup>12</sup> She too was assisted to die.

Only this year, it was revealed that one elderly dementia patient was euthanized at the request of their family, without having previously requested such intervention: "the patient lacked the mental capacity to ask for euthanasia and the request for the bedridden patient to be killed came from family members."<sup>13</sup> The case has come to public attention only through a letter to the Associated Press, written by Dr. Ludo Vanopdenbosch, explaining his resignation from Belgium's euthanasia commission over this and other cases which fail to meet the legal criteria for euthanasia and yet have not been forwarded for the attention of the public prosecutor's office.<sup>14</sup>

### *The Netherlands*

A similar trajectory is clear in the case of the Netherlands, where euthanasia laws have provoked concern from the United Nations.<sup>15</sup> The creation of a culture which normalises euthanasia was explained to the UK House of Lords by Lord McColl after a visit to Holland as a member of the Select Committee on Medical Ethics in which he recalls:

*The Dutch doctors told us, 'We agonised over our first case of euthanasia all day, but the second case was much easier and the third was a piece of cake'. We found that rather chilling.*<sup>16</sup>

Lord McColl went on to say:

*There is empirical evidence to show that the current practice of euthanasia in the Netherlands is out of control ... Professor John Griffiths of the University of Groningen ... states that the system of regulation is not working. Doctors are not reporting cases of euthanasia that they are practising and this is confirmed by the conclusions of the Rummelink Commission which found that the number of reported cases of euthanasia was as low as 18 per cent.*<sup>17</sup>

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<sup>11</sup> See Bruno Waterfield (January 15, 2013), 'Euthanasia twins 'had nothing to live for'', *Sydney Morning Herald*, <http://www.smh.com.au/world/euthanasia-twins-had-nothing-to-live-for-20130115-2cq9z.html>.

<sup>12</sup> Damien Gayle, "Transsexual, 44, elects to die by euthanasia after botched sex-change operation turned him into a 'monster'", *Daily Mail*, 2<sup>nd</sup> October 2013. Available at: <http://www.dailymail.co.uk/news/article-2440086/Belgian-transsexual-Nathan-Verhelst-44-elects-die-euthanasia-botched-sex-change-operation.html>

<sup>13</sup> Mike Corder, "Euthanasia dispute in Belgium: When do doctors cross a line?", *Healthworld*, 17 February 2018. (Available here: <https://health.economictimes.indiatimes.com/news/industry/euthanasia-dispute-in-belgium-when-do-doctors-cross-a-line/62954888>).

<sup>14</sup> Mike Corder, "Euthanasia dispute in Belgium: When do doctors cross a line?", *Healthworld*, 17 February 2018. (Available here: <https://health.economictimes.indiatimes.com/news/industry/euthanasia-dispute-in-belgium-when-do-doctors-cross-a-line/62954888>).

<sup>15</sup> Concluding Observations on the Netherlands (2001) Un doc. CCPR/CO/72/NET, para 5(b), <http://www.unhcr.ch/tbs/doc.nsf/0/dbab71d01e02db11c1256a950041d732>.

<sup>16</sup> House of Lords Hansard, UK Parliament, columns 707–708. Available here: <https://publications.parliament.uk/pa/ld199798/ldhansrd/vo980506/text/80506-12.htm>

<sup>17</sup> House of Lords Hansard, UK Parliament, 6 May 1998, Column 709. Available here: <https://publications.parliament.uk/pa/ld199798/ldhansrd/vo980506/text/80506-12.htm>

Psychiatric patients are being euthanised in the Netherlands. Thirteen psychiatric patients were euthanised in 2011, while a further 49 patients in the early stages of dementia were euthanised.<sup>18</sup>

The euthanasia earlier this year of a woman in her 70s who suffered from dementia, demonstrates how ostensibly benevolent intentions of even carefully-considered legislation may be confounded in practice. This woman had completed a living will, saying she did not want to go into a home and that she wished to die when she considered the time was right. After her condition deteriorated, she was placed in a nursing home where she became fearful and angry and took to wandering through the corridors at night. The nursing home doctor reviewed her case and decided that the woman was suffering unbearably, which would justify her wish to die.

The presiding doctor drugged the patient's coffee, to quieten her while the fatal drip was inserted. However, the patient rallied unexpectedly and began struggling so that the doctor was obliged to call on the woman's family to hold her down while the lethal dose was administered. The medical Regional Review Committee subsequently determined that the doctor involved did not break the law, although they conceded that she "crossed the line" by giving the patient sleeping medicine, and should have stopped when the woman resisted.<sup>19</sup> Obviously, even if the board had found mal-practice, compensation for a victim of 'involuntary euthanasia' is impossible<sup>20</sup>.

Despite the law requiring unbearable pain as a condition for euthanasia, 20% of Dutch GPs surveyed said they were willing to euthanize a patient who is merely "tired of life".<sup>21</sup> In 2016, the family of 41-year-old Mark Langedijk were vocal in their complaints about the widening of euthanasia laws that enabled Mark to choose death as the best solution to his ongoing struggle with alcoholism:

*Before receiving the fatal injections, Mr Langedijk sat on a bench in his parents' garden and drank beer. He told jokes, ate ham and cheese sandwiches and soup with meatballs, until the doctor arrived at 3.15 in the afternoon ... Mark Langedijk drank a last glass of white wine, smoked a cigarette, but turned down another one because 'I'm dying now', Marcel Langedijk said.<sup>22</sup>*

The article reporting this in the UK press noted that:

*the scope of mercy killing law, introduced 16 years ago to apply only to those in unbearable suffering, has already widened so that those who die include many whose problems include 'social isolation and loneliness.'<sup>23</sup>*

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<sup>18</sup> DutchNews (September 25, 2012), '13 psychiatric patients were helped to die last year', *DutchNews.nl*, [http://www.dutchnews.nl/news/archives/2012/09/euthanasia\\_case\\_rise\\_steeply.php](http://www.dutchnews.nl/news/archives/2012/09/euthanasia_case_rise_steeply.php).

<sup>19</sup> Editorial: "Doctor reprimanded for 'overstepping mark' during euthanasia on dementia patient", *Dutch News*, 29 January 2017. Available at: <http://www.dutchnews.nl/news/archives/2017/01/doctor-reprimanded-for-overstepping-mark-during-euthanasia-on-dementia-patient/>

<sup>20</sup> This case also illustrates the danger of advanced care directives, when a document written in one set of circumstances can be used to over-ride the changed wishes of a patient.

<sup>21</sup> DutchNews.nl (29 July, 2011), 'One third of doctors have refused a euthanasia request', [http://www.dutchnews.nl/news/archives/2011/07/one\\_third\\_of\\_doctors\\_have\\_refu.php](http://www.dutchnews.nl/news/archives/2011/07/one_third_of_doctors_have_refu.php).

<sup>22</sup> Steve Doughty, "Dutch euthanasia law used to kill alcoholic, 41, who decided death was the only way to escape his problems", *Daily Mail*, 29 November 2016. Available at: <http://www.dailymail.co.uk/news/article-3980608/Dutch-euthanasia-law-used-kill-alcoholic-41-decided-death-way-escape-problems.html>

<sup>23</sup> Steve Doughty, "Dutch euthanasia law used to kill alcoholic, 41, who decided death was the only way to escape his problems", *Daily Mail*, 29 November 2016. Available at: <http://www.dailymail.co.uk/news/article-3980608/Dutch-euthanasia-law-used-kill-alcoholic-41-decided-death-way-escape-problems.html>

Another Dutch case illustrating the slippery slope in practice concerns the euthanasia of an unnamed woman in her 20s who had been the victim of child sex abuse. The doctors believed her consequent mental suffering and post-traumatic stress disorder to be incurable.<sup>24</sup> In the Netherlands, euthanasia is legal for children from the age of 12<sup>25</sup> and for infants under the age of 12 months under the Groningen protocol.<sup>26</sup> Paediatricians are now pushing for allowing euthanasia for children of any age.<sup>27</sup> A scheme was introduced in 2012 to send “mobile euthanasia units” around the country to euthanise patients whose own doctors refuse to do so.<sup>28</sup>

Prof Theo Boer, a former member of a Dutch Regional Euthanasia Committee who previously advocated for euthanasia, has changed his mind after reviewing 4000 recent cases. In July 2014 he warned the UK following the Dutch example:

*I was wrong, terribly wrong in fact, to believe that regulated euthanasia would work ... Whereas in the first years after 2002 hardly any patients with psychiatric illnesses or dementia appear in reports, these numbers are now sharply on the rise. Cases have been reported in which a large part of the suffering of those given euthanasia or assisted suicide consisted in being aged, lonely or bereaved. Some of these patients could have lived for years or decades ... Some slopes truly are slippery.*<sup>29</sup>

#### The availability of euthanasia as a choice produces pressure

A separate objection to euthanasia concerns the impossibility of ever entirely comprehending another person’s motivation. Advocates for euthanasia argue for the importance of giving effect to ‘free choice’. (Presumably, no one who advocates for euthanasia would do so if it meant ending a person’s life against their will, in circumstances where their free choice is compromised by other considerations or where this decision is taken in response to pressure). Free choice can only be said to exist if all other possible motivations to hasten death can be absolutely ruled out. Since no one can fathom the internal processes of another soul – since this choice cannot be clinically isolated from other complicating considerations which may cloud the purity of that choice and thus compromise the freedom with which it is made – the necessary conditions for purely free decision-making are never achievable in practice.

Pressure to end one’s life may be direct or indirect.

<sup>24</sup> Matt Payton, “Sex abuse victim in her 20s allowed by doctors to choose euthanasia due to ‘incurable’ PTSD”, *Independent*, 11 May 2016. Available here: <http://www.independent.co.uk/news/world/europe/sex-abuse-victim-in-her-20s-allowed-by-dutch-doctors-to-undergo-euthanasia-due-to-severe-ptsd-a7023666.html>

<sup>25</sup> See Article 2, sections 2 and 3, of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

<sup>26</sup> Eduard Verhagen and Peter JJ Sauer, ‘The Groningen Protocol – Euthanasia in Severely Ill Newborns’, *The New England Journal of Medicine*, 10 March 2005. (Available here: <http://www.nejm.org/doi/full/10.1056/NEJMp058026>).

<sup>27</sup> Anneke Stoffelen, ‘Physicians ‘Make euthanasia possible child up to 12 years’’, *Volkskrant.nl*, 7 July 2014. (Available here: <http://www.volkskrant.nl/vk/nl/2672/Wetenschap-Gezondheid/article/detail/3684922/2014/07/07/Artsen-Maak-euthanasie-mogelijk-bij-kind-tot-12-jaar.dhtml>).

<sup>28</sup> Kate Connolly, “Dutch mobile euthanasia units to make house calls”, *The Guardian*, 1 March 2012, <http://www.guardian.co.uk/world/2012/mar/01/dutch-mobile-euthanasia-units>.

<sup>29</sup> Alex Schadenberg, “Dutch professor now opposes euthanasia: ‘I was terribly wrong, in fact’”, Euthanasia Prevention Coalition, 10 July 2014. (Available at: <http://alexschadenberg.blogspot.com.au/2014/07/dutch-professor-now-opposes-euthanasia.htm>).

### *Direct pressure*

Legislated safeguards offer the vulnerable imperfect protection against overt, direct pressure. Governments can legislate narrow circumstances in which euthanasia is allowable, they can stipulate multiple medical opinions, cooling off periods and guidelines for counselling of the patient, etc. However, even with the best safeguards in an ideal world, no system of protections will ever be entirely impregnable to individuals of ill-will who are motivated to circumvent them. Family and doctors are trusted to act entirely in the best interests of their patients and loved ones. On the other hand, it is well-known that most abuse of the elderly occurs at the hands of family members, typically adult children, and that doctors, however well-meaning, may be subjected to pressure. A 2011 survey of 800 family doctors in the Netherlands found that nearly half had “felt pressured by patients or their relatives” to use euthanasia.<sup>30</sup>

An example of such pressure can be found in the Dutch case referred to by Lord Ashbourne in the House of Lords euthanasia debates, in which an old man was dying of lung cancer:

*His symptoms were controlled and he asked if he could die at home. When his children were told about his wish they would not agree to take care of him. Even after repeated discussion, they refused. Instead, they pointed to their father's suffering and the need to finish things quickly in the name of humanity. When the doctor refused, they threatened to sue him. As the patient insisted on going home, a social worker went to investigate. She discovered that the patient's house was empty and every piece of furniture had been stripped out by the family.<sup>31</sup>*

Laws must anticipate human failing. They cannot assume all families, however apparently loving, are entirely free of ulterior motives in hastening the end of elderly relatives. “Inheritance impatience” is a recognised motivating factor for some adult children of older parents in wishing to hasten their death, as is the wish to avoid the expense and burden of caring for them. Whether through nefarious activity or undue pressure to hasten death, the risk of ‘involuntary euthanasia’ for vulnerable individuals is unavoidably greater where voluntary euthanasia is accepted practice.<sup>32</sup>

These risks cannot be entirely eradicated even by very careful legislation. In 1994, the UK’s House of Lords Select Committee on Medical Ethics concluded that it would be:

*virtually impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation of the law ... could not be abused. We were also concerned that vulnerable people—the elderly, lonely, sick or distressed—would feel pressure, whether real or imagined, to request early death.<sup>33</sup>*

A 1998 Tasmanian Parliamentary Committee reached a similar conclusion:

*The Committee found that the legalisation of voluntary euthanasia would pose a serious threat to the more vulnerable members of society and that the obligation*

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<sup>30</sup>“One third of doctors have refused a euthanasia request”, 7 *DutchNews.nl*, 29 July, 2011. Available at: [http://www.dutchnews.nl/news/archives/2011/07/one\\_third\\_of\\_doctors\\_have\\_refu/](http://www.dutchnews.nl/news/archives/2011/07/one_third_of_doctors_have_refu/)

<sup>31</sup> House of Lords Hansard, UK Parliament, 6 May 1998, Column 723.

<sup>32</sup> F. Norwood, G. Kimsma, and M. Battin, “Vulnerability and the ‘Slippery Slope’ at the End-of-life: a qualitative Study of Euthanasia, General Practice and Home Death in the Netherlands”, *Family Practice*, vol. 26, p. 472.

<sup>33</sup> Select Committee on Medical Ethics. Report. London: HMSO, 1994. (House of Lords paper 21-I).

*of the state to protect all its members equally outweighs the individual's freedom to choose voluntary euthanasia.*<sup>34</sup>

More recently, in *Haas v. Switzerland*, the European Court of Human Rights considered that

*“the risk of abuse inherent in a system which facilitated assisted suicide could not be underestimated.”*<sup>35</sup>

Were it possible to devise perfect legislative safeguards, it would still be impossible to ensure that the letter of the law would be observed in all cases and that no one would feel pressured to end their lives prematurely. Risk, even from direct pressure, cannot be legislated away.

### *Indirect pressure*

Any discussion of the possibility of pressure being applied for the elderly or terminally-ill to end their lives prematurely must acknowledge the operation of indirect pressure, which occurs merely because euthanasia is one available end-of-life choice. To imagine that the ability to choose death does not impose pressure on the vulnerable is to believe in a world where every individual operates in complete autonomy and can be trusted to make entirely selfish choices, without any consideration for the effects of these decisions on others. Such a world does not exist.

The first principles of social psychology address the fact that we live in community, we make decisions with reference to the common good and for the benefit of those around us all the time. Reduced autonomy is an unavoidable corollary of aging, where dependence on others necessarily increases. If governments could ensure no friend, relative or doctor of an elderly person would ever whisper to them privately that they should consider suicide (and they clearly cannot ensure this), even that would not ensure that the elderly were free from pressure (even if this exists only in their own perceptions) to consider suicide simply because this choice would remove the burden of caring for them from those they love.

In the moment that end-of-life choices includes euthanasia, those aspects of care that are perceived as the ‘indignities of aging’ and the inevitable burden that caring for the aged entails are changed from being inevitable and necessary to being avoidable and the product of ‘choice’. The old person who could choose death is now a burden for others through their own selfish choice to stay alive. Such a choice may well be resented by those required to care for them or pay for their care. Circumstances are not difficult to envisage in which such old people come to regard killing themselves as ‘the right thing to do’.<sup>36</sup> In 2012 in Oregon, 57% of those requesting death reported ‘burden to family and friends’ as an end-of-life concern.<sup>37</sup>

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<sup>34</sup> “The Need for Legalisation on Voluntary Euthanasia”, Community Development Committee Report No. 6, 1998, paragraph 5:29. (Available at: [http://www.parliament.tas.gov.au/ctee/old\\_ctees/euth.htm](http://www.parliament.tas.gov.au/ctee/old_ctees/euth.htm))

<sup>35</sup> Press Release: “Switzerland Cannot be Criticised for Not Having Assisted a Suicide”, European Court of Human Rights, Press Release issued by the Registrar of the Court, no. 040, 20<sup>th</sup> January 2011. Available here: <https://hudoc.echr.coe.int/eng-press/>; (Registrar of the European Court of Human Rights, 2011: 3).

<sup>36</sup> Hannah Graham and Jeremy Prichard (October 2013), ‘Voluntary Euthanasia and ‘Assisted Dying’ in Tasmania: A Response to Giddings & McKim’, October 2013. Available at <http://www.bestcare.com.au/documents/reports/Voluntary-Euthanasia-and-Assisted-Dying-in-Tasmania-A-Response-to-Giddings-and-McKim-Oct2013.pdf>, p. 14.

<sup>37</sup> Oregon Public Health Division, *Oregon’s Death With Dignity Act 2012 [Annual Report Year 15]* Oregon Public Health, 2013, Salem, p. 5. (Available at: <http://www.livinganddyingwell.org.uk/sites/default/files/LDW%20-%20Research%20-%20Oregon%20Year%2015.pdf>)

If laws are changed to allow voluntary euthanasia, indirect pressure is the inevitable result. No government can legislate safeguards against it. The elderly and terminally ill are only protected from indirect or perceived pressure to choose euthanasia by firm legislation prohibiting assisted dying and by the powers of the government arrayed to prosecute any who break this law. The law cannot be changed to accommodate the wishes of the few without exposing the many to pressure to choose euthanasia.

The risks that legal euthanasia poses to the vulnerable thus come in different forms which include direct pressure and indirect pressure to choose death for the benefit of others or for lack of other good options. The end result of both circumstances is that someone dies when they otherwise would live and the State has contributed to their death by failing to offer sufficient protections. Since death is irreversible, there is no opportunity for injustice to be appealed or victims to be compensated. In such matters of life and death governments must exercise the highest duty of care for all citizens by not enacting legislation that would increase the vulnerability of society's most vulnerable.

### When do we agree that suicide is the right thing to do?

The argument has been made that euthanasia will be contemplated only for the terminally ill. These people may be weeks or months away from death but in all cases, their death is not imminent. In Victoria, the initial proposal for an estimated time of death of twelve months was only reduced to six months after extensive, hard-fought parliamentary debate. Even in these more limited circumstances, two principal problems arise. The first concerns the message unavoidably sent to vulnerable population groups that, for some, suicide is the best choice. The second concerns the potential for mis-diagnosis.

### Promoting suicide prevention, while offering assisted suicide is contradictory

The benefits argued by the few vocal advocates for legalising assisted suicide must be weighed against the risks such a paradigmatic shift presents to other members of the community, particularly the disabled and the elderly. At the moment, suicide is generally regarded as tragic and our efforts as a society are extended in the direction of suicide prevention and assistance for those tempted to consider it. Legalising assisted suicide necessarily changes that and raises the question of when do we decide suicide is the right thing to do?

Euthanasia or assisted suicide can only be understood as distinct from 'regular' suicide when we value some lives more highly than others and accept a distorted concept of mercy. For example, (incredibly) suicide among the elderly or disabled is sometimes proposed as an argument *for* legalising euthanasia.<sup>38</sup> According to this logic, suicide in some people (particularly young, able-bodied people) is a tragedy, to be prevented by whatever means possible. For others, whose lives really are terrible (such as the elderly or the disabled), death might be the most merciful thing. It is important to note that suicide (assisted or otherwise) for the elderly and disabled can only be regarded with equanimity

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<sup>38</sup> For example, Dr Sally Talbot, addressing the Western Australian Parliament, gave the example of a quadriplegic man who, having tried to end his life on several occasions, eventually starved himself to death. Considering "whether that was the best we could do for that man", she concludes that "it clearly was not." According to Talbot, a better solution would be to facilitate his suicidal intentions through assisted suicide. Extract from Parliament of Western Australia Hansard [COUNCIL — Tuesday, 22 August 2017] p3065c-3082a. (Available here: [http://www.parliament.wa.gov.au/Hansard/hansard.nsf/0/f259b0841209db8e48258187001ed14c/\\$FILE/C40+S1+20170822+p3065c-3082a.pdf](http://www.parliament.wa.gov.au/Hansard/hansard.nsf/0/f259b0841209db8e48258187001ed14c/$FILE/C40+S1+20170822+p3065c-3082a.pdf)).

by those who hold discriminatory views; for whom suicide in the elderly or disabled is somehow less tragic than it would be for someone younger or more able-bodied.

### *The Disabled*

In her address to the Victorian Parliament, disability rights advocate, Liz Carr pointed out how this increases the vulnerability of the disabled:

*If there was a non-disabled person at a railway bridge about to jump, what do we do? Do we go up to them and go ‘you know what, in the name of autonomy and self-determination, you do this. If this is your choice, you do it.’ I don’t think we do that usually. We usually stop them ... We question their mental health. We would see it as a tragedy if it had occurred.*

*Now, if that person was ... disabled ... would we act the same? ... My betting is a lot of people would not act the same. They would go ‘If that person wants to end their life, I understand why because if I was like that, I’d feel the same.’ ... So then we start to call it about choice ... For me, if you even see those two people as different, and those two situations as different, that suggests we do have an unconscious bias and discrimination. So legislation is unsafe already because not everyone starts out as having equal value under the law or in the medical profession or in public perception.<sup>39</sup>*

Unavoidably, legalised euthanasia gives the support of law to the proposition that some lives are not worth living.

*The Oregon experience at least suggests that suicide as a culturally accepted “value” and legislation permitting “assisted suicide” go together. The culture of suicide, given its imprimatur by the state, confounds the efforts of parents and caregivers. There’s something patently contradictory in a state’s provision of, on the one hand, a suicide hotline and, on the other, assisted suicide. The depressed and disabled need our care and encouragement.<sup>40</sup>*

Agitation to change laws to permit assisted suicide is often motivated by the wealthy, white, worried well; the younger generation, whose members derive comfort from the knowledge that they control the end of their lives, that the process of aging and dying need involve no loss of dignity. A confronting response to this argument has been articulated by the disability rights group *Not Dead Yet*, when they state what should be obvious, but has somehow been overlooked: “we don’t need to die to have dignity”. They explain:

*In a society that prizes physical ability and stigmatizes impairments, it’s no surprise that previously able-bodied people may tend to equate disability with loss of dignity. This reflects the prevalent but insulting societal judgment that people who deal with incontinence and other losses in bodily function are lacking dignity. People with disabilities are concerned that these psycho-social disability-related*

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<sup>39</sup> Liz Carr, op.cit.

<sup>40</sup> Arthur Goldberg and Shimon Cowen, “The Contagion of Euthanasia and the Corruption of Compassion”, *Public Discourse*, The Witherspoon Institute, 11 September 2017. Available here: <http://www.thepublicdiscourse.com/2017/09/19983/>.

*factors have become widely accepted as sufficient justification for assisted suicide.*<sup>41</sup>

### *The Elderly*

Such discriminatory thinking is already causing callous disregard for the welfare of the elderly and informs a systematic failure to examine why their lives ‘really are terrible’ and what could be done to make them less so. Advocacy groups for the elderly have termed these ‘the suicides we choose to ignore’. An Australian study investigating patterns of suicide among the elderly (the largest study of its type in the world) has been published just this month in the *International Journal of Geriatric Psychiatry*. The study found that, of suicides in the 65+ age bracket:

*nearly 70% ... were male, 66% had a diagnosis of depression and nearly 80% were experiencing one or more major life stresses, such as health deterioration. Around 43% were experiencing isolation and loneliness, and nearly 30% had trouble adjusting to life in a nursing home.*<sup>42</sup>

This information should prompt further questions: why are men more susceptible? How can we support men better? What contributes to depression and what can we do about it? How can we help the elderly cope with major life stresses? How can we alleviate isolation and loneliness? While the conversation revolves around euthanasia, even when the answers to some of these questions are known, they still go unaddressed.

The authors of this study also note that 50% of residents in aged care facilities show signs of depression, compared with just 10–15% of those living in the community. This figure alone contradicts the view that depression is “a natural part of the aging process”.<sup>43</sup> Living alone, rather than mental illness, has been found to be a significant predictor of suicide for the elderly.<sup>44</sup> 40% of the elderly living in aged care facilities do not receive a single visit from friends or family in the course of a whole year.<sup>45</sup> Recent investigations into the deaths of older people in the Oakden care facility in South Australia revealed conditions which might reasonably cause depression and suicidal ideation in anyone.<sup>46</sup> Why is it then, that every effort is made to avert suicide for those aged 15–29 years, but the same rigor is not applied to alleviating the difficulties that might lead to suicidal ideation for the

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<sup>41</sup> *Not Dead Yet*, (<http://notdeadyet.org/disability-rights-toolkit-for-advocacy-against-legalization-of-assisted-suicide>).

<sup>42</sup> Briony J. Murphy, Lyndal C. Bugeja, Jennifer L. Pilgrim, Joseph E. Ibrahim, “Suicide among nursing home residents in Australia: A national population-based retrospective analysis of medico-legal death investigation information”, *International Journal of Geriatric Psychiatry*, 5 March 2018. (Available here: <https://doi.org/10.1002/gps.4862>).

<sup>43</sup> Briony Murphy and Joseph Ibrahim, “Too many Australians living in nursing homes take their own lives”, *The Conversation*, 6 March 2018. (Available here: <https://theconversation.com/too-many-australians-living-in-nursing-homes-take-their-own-lives-92112>).

<sup>44</sup> Paul Donoghue, Why are elderly Australians taking their own lives?: searching for answers to ‘the suicides we ignore’, *ABC News*, 4 October 2016. (Available here: <http://www.abc.net.au/news/2015-10-08/mental-health-depression-elderly-suicide/6808998>).

<sup>45</sup> The Hon Ken Wyatt, Federal Minister for Aged Care and Minister for Indigenous Health, “Australia’s New Age of Opportunity”, National Press Club, Canberra, 25 October 2017. (Available here: [http://www.health.gov.au/internet/ministers/publishing.nsf/Content/16F076192D82B487CA2581C4000D5486/\\$File/KW171025.pdf](http://www.health.gov.au/internet/ministers/publishing.nsf/Content/16F076192D82B487CA2581C4000D5486/$File/KW171025.pdf)).

<sup>46</sup> Nick Harmsen, “SA Premier ‘deeply sorry’ after Oakden ICAC reports five individuals for maladministration”, *ABC News*, 28 February 2018. (Available here: <http://www.abc.net.au/news/2018-02-28/icac-report-on-oakden-aged-care-home-released/9492008>).

elderly? The answer can only be discrimination – perhaps unconscious discrimination – against the elderly.<sup>47</sup>

In practice, motivations for choosing to die may be complex. A 2015 survey of patients requesting euthanasia in Oregon revealed the three most significant reasons for this choice concerned a reduction in ability to engage in those activities that made life enjoyable (96%); loss of autonomy (92%) and loss of dignity (75%). By contrast, only 28.7% said they were suffering from ‘inadequate pain control or concern about it’.<sup>48</sup> In jurisdictions that have legalised euthanasia, the State’s inability to provide for vulnerable individuals is certainly a contributing factor to the decision in favour of death. Wim Distelmans, Chairman of the Federal Control and Evaluation Commission and staunch proponent of euthanasia, described how doctors in Belgium have adopted increasingly loose interpretations of disease:

*We at the commission are confronted more and more with patients who are tired of dealing with a sum of small ailments—they are what we call ‘tired of life.’” Although their suffering derives from social concerns as well as from medical ones, Distelmans said that he still considers their pain to be incurable. “If you ask for euthanasia because you are alone, and you are alone because you don’t have family to take care of you, we cannot create family.”<sup>49</sup>*

Clearly social causes of unhappiness are at least as difficult to treat as medical ones. As it would be repugnant to offer euthanasia in place of medical help, it ought to be repugnant to offer euthanasia in place of social support. A more humane social policy would be directed to alleviating loneliness, rather than simply killing the lonely. Far from being a reason to introduce euthanasia, suicide among the elderly indicates a significant failure in existing levels of support. Until all other possible motivations for choosing death are removed, the choice to suicide cannot be assumed to be the expression of autonomy, or unrestricted free choice. A choice is only a free choice when there are at least two good options.

### Misdiagnosis in some cases is inevitable

If the possibility of wrongful conviction mitigates against the death penalty, the potential for misdiagnosis must invalidate euthanasia. Even understandings of what constitutes a ‘terminal illness’ are potentially elastic. “A patient can be classified as ‘terminal’ if they reject any treatment needed to keep them alive, for example kidney dialysis or insulin for a diabetic.”<sup>50</sup> The same challenges previously noted to contribute to the ‘slippery slope’ may therefore apply even to terminology that legislators think is capable of only limited interpretation.

Dr Stephen Parnis, former President of the Australian Medical Association, prepared a report *Voluntary Assisted Dying: the promise vs the reality* to assist the Victorian Parliament in their consideration of this subject. In it, Parnis argued that:

<sup>47</sup> Brian Draper, “Elderly men have the highest suicide rate – and ageism stops us from doing something about it”, *The Conversation*, 3 September 2015. (Available here: <https://theconversation.com/elderly-men-have-the-highest-suicide-rate-and-ageism-stops-us-from-doing-something-about-it-46923>).

<sup>48</sup> “Oregon Death with Dignity Act: 2015 Data Summary”, Oregon Health Authority, 4<sup>th</sup> February 2016, p. 6. Available at: <http://www.worldrtd.net/sites/default/files/newsfiles/Oregon%20report%202015.pdf>

<sup>49</sup> Rachel Aviv, op. cit.

<sup>50</sup> S. Kouwenhoven et al, “Opinions of health care professionals and the public after eight years of euthanasia legislation in the Netherlands: A mixed methods approach”, *Palliative Medicine*, vol. 27(3), 2013, pp. 273–280.

*The prediction of a life expectancy of up to 12 months is notoriously difficult and inaccurate, even for highly experienced medical specialists. What we do know for certain is that people have lived well beyond a 12 month prognosis.<sup>51</sup>*

A 2000 study of doctors' prognoses for terminally ill patients found that only 20% of predictions were accurate within 33% of actual survival time.<sup>52</sup> In Washington, 14% of the 835 recorded deaths under the assisted suicide law since 2009, have occurred 25 weeks or more after a prognosis of no more than 6 months to live.<sup>53</sup> (Washington requires a prognosis of 6 months, not 12). In Oregon, there has been a similar experience. The record has been that a patient has ingested the lethal dose 2 years 9 months after a prognosis of "six months to live".<sup>54</sup>

In 2015, the Vermont Alliance for Ethical Healthcare has produced a document entitled *Doctors Often Misdiagnose the Terminally Ill*.<sup>55</sup> It lists several cases from the Vermont area alone that support this central contention:

- Erica Riel had been diagnosed with a terminal illness three times by Vermont doctors, only to learn later that that was untrue. She wanted to give up but her family convinced her to try one more doctor. Ultimately, she went to a doctor in Massachusetts who told her that she would not only live, but live to be 80 years old!
- Jeannine Young testified that, "My father lived 20 years longer than predicted. Doctors told my father that he would not live through the winter of 1962–63, so my eldest sister moved her wedding date up from June 1963 to December 1962, so he could walk at least one of his six daughters down the aisle ... My father died in November of 1982, living long enough for sixteen of his twenty grandchildren to be born and long enough for his first granddaughter's wedding."
- Clara Schoppe is a Vermont mother and grandmother who will soon be 66 years old, and she is a cancer survivor. She was told that she had Stage 4 non-Hodgkins Lymphoma, that it was terminal, incurable, and it was throughout her bone marrow and that she had less than a year to live. That was 24 years ago.
- Mrs. Rob Carlson also testified at the public hearing that doctors did not expect her husband to live as a result of his illness. He lived for an additional 14 years.
- Jack Caufield was diagnosed in 2002 with pancreatic cancer which appeared to have spread to his liver and his prognosis was grim. A year later, his doctors again told him that his illness was incurable and this time he was given the feared "get your affairs in order and prepare to die" pronouncement. Jack ultimately lived for 3 and a-half years longer than the doctors predicted. He testified in the Vermont House against physician-assisted suicide because

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<sup>51</sup> Dr Stephen Parnis, *Voluntary Assisted Dying: the promise vs the reality*, p. 10. (Attached in Appendix D).

<sup>52</sup> N.A. Christakis, J.L. Smith, C.M. Parkes, and E.B. Lamont, "Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study", *British Medical Journal*, vol. 320, 2000, p. 469. (Retrieved from <https://doi.org/10.1136/bmj.320.7233.469>).

<sup>53</sup> Washington State Department of Health, Death with Dignity Act, Reports, 2009–2016 available at: <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityActDeathwithDignityData>, p. 9.

<sup>54</sup> Oregon Public Health Division, Oregon Death With Dignity Act: Data Summary 2016, <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf>, p.11.

<sup>55</sup> Available here: <http://www.vaeh.org/doctors-often-misdiagnose-the-terminally-ill/>

doctors make mistakes, and because he knew that if he had been depressed and asked for assisted suicide, he would have missed all the extra time he enjoyed with his family.

The concerns expressed by these patients and their families were realised in the case of Pietro D'Amico, a 62-year-old Italian magistrate whose suicide was facilitated in 2013 by the Dignitas clinic in Basel, Switzerland. D'Amico had been diagnosed by both Italian and Swiss doctors with a life-threatening illness – a diagnosis which the subsequent autopsy proved to be entirely incorrect.<sup>56</sup>

For outpatient treatments in America, misdiagnosis is estimated to affect about 5% of patients.<sup>57</sup> This is regarded as unacceptably high, equating to 12,000,000 mistakes of diagnosis per year. Misdiagnosis accounts for 10% of patient deaths and 17% of adverse events in American hospitals.<sup>58</sup> A 2012, study of autopsies on ICU patients in Britain found 28% had at least one misdiagnosis.<sup>59</sup> A 2013 study from the John Hopkins University Hospital, reviewing 25 years of malpractice claim payouts in the US, found that diagnostic errors accounted for the largest percentage of such malpractice claims and the most severe patient harm:

*Researchers estimate the number of patients suffering misdiagnosis-related, potentially preventable, significant permanent injury or death annually in the United States ranges from 80,000 to 160,000.<sup>60</sup>*

Similar research has noted that there is a trade-off already being made between controlling the cost of diagnostic work to national health budgets and the cost of misdiagnosis borne by patients who might suffer death or permanent injury as a result of inadequate testing.<sup>61</sup>

Most cases of euthanasia will not be followed by an autopsy, so the number of cases affected by misdiagnosis cannot even be estimated. Indeed, most jurisdictions in which euthanasia is permitted allow the certifying doctor to record the cause of death as the illness thought to be afflicting their patient. This falsification of legal records would in itself frustrate subsequent investigation. It will be impossible to quantify the extent to which the assumptions of medical accuracy upon which arguments for euthanasia are founded are, in fact, unsound. What can be certainly established is that, if euthanasia is legalised, the risk of death resulting from a misdiagnosis of a terminal illness is substantially increased. Pietro D'Amico would not have died if he had not been euthanised by the Dignitas clinic.

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<sup>56</sup> "Aided suicide in question after botched diagnosis", *The Local*, 11 July 2013, <https://www.thlocal.ch/20130711/assisted-suicide-in-question-after-botched-diagnosis>.

<sup>57</sup> Jessica Firger, "12 million Americans Misdiagnosed each year", *CBS News*, 17<sup>th</sup> April 2014. Available here: <https://www.cbsnews.com/news/12-million-americans-misdiagnosed-each-year-study-says/>

<sup>58</sup> "Most Americans Will Be Misdiagnosed at Least Once", Department of Health and Human Services OFFICE OF INSPECTOR GENERAL, USA, November 2010. Available here: <https://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf>

<sup>59</sup> B. Winters, J. Custer, S.M. Galvagno, *et al*, "Diagnostic errors in the intensive care unit: a systematic review of autopsy studies", *British Medical Quarterly*, 2012, vol. 21(11), pp. 894–902.

<sup>60</sup> A.S. Saber Tehrani, H. Lee, S.C. Mathews, *et al*, "25-Year summary of US malpractice claims for diagnostic errors 1986–2010: an analysis from the National Practitioner Data Bank", *British Medical Journal – Quality and Safety*, 2013, vol. 22, pp. 672–680.

<sup>61</sup> D.E. Newman-Toker, K.M. McDonald, D.O. Meltzer, "How much diagnostic safety can we afford, and how should we decide? A health economics perspective", *British medical Journal – Quality and Safety*, vol. 22(ii), pp. 11–20.

## Does legalisation improve regulation of euthanasia?

The argument has been made, for example by the Victorian Premier Daniel Andrews<sup>62</sup>, that physician assisted suicide is already happening in Australia and that the legalisation of euthanasia will assist governments to ensure this practice is properly regulated. If the testimony of Lord Laverne, addressing the House of Lords, is to be believed then Andrews is right as to the first point. Laverne claimed that:

*“in Australia, where euthanasia is illegal, the proportion of deaths without consent ...[is] 3.5 per cent.”*<sup>63</sup>

However, if Australia already has a problem regulating “unofficial” euthanasia, the argument that relaxing the law to allow for greater scrutiny of this practice, is self-defeating. If current legal safeguards are already failing to protect the vulnerable from being killed against their will in hospitals and hospices – if doctors are already making moral, rather than medical, judgements about the value of different lives – this should signal an environment in which further relaxation of protective legalisation could only increase the dangers for patients.

This has certainly been the experience in Holland. In 1991, prior to the legalisation of euthanasia, the Dutch government established a committee headed by Justice Remmelink to find out the extent to which euthanasia was occurring “unofficially”. The report showed that more than 3,000 people had been euthanised in the previous year and that, in 1030 of these cases, this had been done without a specific request from the patient.<sup>64</sup> Despite these findings, the Dutch Parliament legalised euthanasia with the result that the position continued to deteriorate and non-voluntary euthanasia continued to be practiced “without prosecution ... on those who were not dying or incurably ill.”<sup>65</sup>

Tom Mortier (the son of Godelieve de Troyer), has expressed concern that those responsible for investigating euthanasia cases are heavily invested in promoting the practice. Dr Distelmans, who oversaw de Troyer’s death and presides over a clinic offering euthanasia services, also chairs Belgium’s Federal Control and Evaluation Committee on Euthanasia. Other euthanasia advocates also see no problem with putting the fox in charge of the hen house. Professor John Griffiths of the University of Groningen acknowledges the existing problems with reporting but nevertheless urges total decriminalization of euthanasia. He advocates for euthanasia to be understood as a form of medical treatment and for doctors administering lethal drugs to be self-regulating.<sup>66</sup> Surely the dangers inherent in such a proposal are self-evident.

The example of Belgium similarly indicates that, far from ensuring deaths in medical care are better regulated, that instead death has come to be regarded as a trivial matter since euthanasia has been legalised. By 2010 only 52.8% of euthanasia deaths were being reported to the authorities.<sup>67</sup> As of June 2015, “one in every 60 deaths of a patient under GP care involves someone who has not

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<sup>62</sup> Legislative Assembly Hansard, Victorian Parliament, 17 October 2017.

<sup>63</sup> House of Lords Hansard, UK Parliament, 6 May 1998, Column 713. Available here: <https://publications.parliament.uk/pa/ld199798/ldhansrd/vo980506/text/80506-12.htm>

<sup>64</sup> See van P.J. der Maas, J.J. van Delden, L. Pijnenborg, and C. W. Looman, “Euthanasia and other medical decisions concerning the end of life”, *Lancet*, 1991, vol. 338, pp. 669–674.

<sup>65</sup> House of Lords Hansard, UK Parliament, 6 May 1998, Column 708. Available here: <https://publications.parliament.uk/pa/ld199798/ldhansrd/vo980506/text/80506-12.htm>

<sup>66</sup> John Griffiths, Alex Bood, Heleen Weyers, *Euthanasia and Law in the Netherlands*, Amsterdam University Press, 1998.

<sup>67</sup> Smets, Bilsen, Cohen, Rurp, Mortier, Deliens (2010), ‘Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases’, *British Medical Journal*, p. 1, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2950259/pdf/bmj.c5174.pdf>.

requested euthanasia.”<sup>68</sup> Despite Belgian law prohibiting nurses from administering lethal drugs to patients, a 2010 report found that nurses are performing this role in 12% of euthanasia deaths.<sup>69</sup>

### Legalisation of euthanasia increases existing dangers to patients

Returning to the claim that “unofficial euthanasia” is already occurring in Australia, it is important to understand how this can happen, even in jurisdictions when laws exist to prevent it. Euthanasia can be defined as:

*“an act or calculated course of omission intended to shorten life with a supposedly merciful motivation.”<sup>70</sup>*

Euthanasia may therefore happen through commission (as in the case of assisted suicide by administering poison) or omission (where people are denied treatment that would save their life for compassionate reasons). Pain relief in palliative care, where a secondary unintended effect is to hasten the patient’s death, or a treatment is ceased because it is burdensome or medically futile are not euthanasia.

Euthanasia through omission is harder to regulate because it may shade off into those cases in which further medical treatment is deemed futile and burdensome. In theory, the discontinuation of futile and burdensome treatment is not considered euthanasia because it is not primarily motivated by the intention to kill the patient. However, in practice, where the patient is dying anyway, the distinction between discontinuing futile treatment and allowing the patient to die for compassionate reasons may be more difficult to discern and regulate. In such cases, it is particularly important that frameworks are set to ensure the principle of double effect is not being used to screen ‘unofficial euthanasia’. Disability rights groups are already concerned that many of the medical decisions (many of which seem to be made in the Emergency Room under pressure), already reveal a bias about which lives are worth preserving and which are not. Discrimination, even the unconscious discrimination described earlier, puts disabled and elderly lives at risk and creates a permission structure for resource-starved hospitals to refuse treatment.

The experience of Baroness Campbell of Surbiton, related to her peers in the UK House of Lords as they considered the Assisted Dying Bill, illustrates the problem well. Baroness Campbell has spent all her unexpectedly long life battling spinal muscular atrophy (a degenerative, terminal illness). Not expected to survive beyond the age of one or two, she has surprised everyone by reaching the age of nearly 60. According to her own account, emergency trips to hospital with severe breathing difficulties occur at least once a year. Any one of these incidents might be fatal without medical assistance. Always, the doctors have followed a clear procedure and she has recovered. But once, when her husband was obliged to take her to an unfamiliar hospital, the decisions of the doctors nearly proved fatal. She recalls:

*I was panicking, I couldn't breathe, I couldn't even swallow. I was gasping for air while all around me was a blur of doctors. I knew I was in hospital and I knew I*

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<sup>68</sup> R. Cohen-Almagor, “First do no harm: intentionally shortening lives of patients without their explicit request in Belgium”, *Journal of Medical Ethics*, Published Online First: 03 June 2015. (doi: 10.1136/medethics-2014-102387 Available at: <http://jme.bmj.com/content/early/2015/06/03/medethics-2014-102387>).

<sup>69</sup> Inghelbrecht, Bilsen, Mortier, Deliens, ‘The role of nurses in physician-assisted deaths in Belgium’, *Canadian Medical Association Journal*, 2010, p. 1.

<sup>70</sup> A definition adopted by Archbishop Fisher in his historic 2004 debate with euthanasia advocate Dr Philip Nitschke, the definition was later adopted by Professor Peter Singer in a 2015 debate with Archbishop Fisher.

*needed help fast. I had been through this so often before. But this time it was different. I was struggling to breathe and stay conscious but, even so, I knew things weren't going the way they should: the doctors weren't acting quickly enough, they were leaving it too late. I knew the procedures. Didn't they? And I was scared, very, very scared, terrified that I was going to die ...*

*Check any medical book ... it will tell you that, with my condition, being unable to breath and swallow is pretty much endgame. I know those doctors were trying to be kind, wanting to do what they thought was best for me, to ease my suffering by ending my life. But it wasn't what I wanted. And in my heart I knew that, because these doctors didn't know me, they would make assumptions. Assumptions that were utterly wrong.<sup>71</sup>*

The doctors explained their lack of intervention to Baroness Campbell's husband, saying they didn't think they would be able to 'bring her through'. They didn't want to put her on a ventilator because it would be difficult to wean her off it and they didn't think she would want to live on a ventilator.

*Baroness Campbell considers herself very, very lucky. Her husband was able to tell the medical staff what his wife could not: that she already spent every night on a ventilator. And yes, she did want to be resuscitated. Her condition may be degenerative. But she was a fighter, and she wanted to live. To the hospital's shame, he was forced to show doctors photographs of Lady Campbell receiving an honorary doctorate in law from Bristol university to "prove" the quality of her life.<sup>72</sup>*

The Committee will have received a submission from Elizabeth Bartell, in which she details the similar case of her father who, having terminal cancer, was taken to hospital because of breathing difficulty where the doctor apparently ordered fluids to be withdrawn, under the belief that her father would die that day. Finding him severely dehydrated, his family were told of the doctor's orders to withhold fluids and so took shifts by his bedside to ensure he drank whenever he was awake. He recovered and lived another year.

Obviously, there are grey areas about when doctors should and should not pursue treatment that they regard as futile. These dangers exist and deserve to be addressed in their own right. The point is that the legalisation of euthanasia only increases the existing dangers to terminally ill or disabled patients, extending the risk from situations in which doctors may decide to withhold treatment, to situations where doctors intentionally act to kill the patient.

*"A law permitting euthanasia would reinforce this position, further clearing the ground to take away lives based on a moral judgment rather than medical fact. The threat will extend to the lives of older, disabled people too."<sup>73</sup>*

### Are doctors healers or arrangers of death?

Inevitably, the legalisation of euthanasia fundamentally changes the relationship between a patient and their doctor. Euthanasia becomes one of a number of 'medical treatments' that doctors may

<sup>71</sup> Olga Craig, "Baroness Campbell: Believe me, I absolutely love my life", *The Telegraph*, 12 July 2009. Available at: <http://www.telegraph.co.uk/news/5803716/Baroness-Campbell-Believe-me-I-absolutely-love-my-life.html>

<sup>72</sup> Olga Craig, op. cit.

<sup>73</sup> Martin Beckford, "Fearful elderly people carry 'anti-euthanasia cards'", *The Telegraph*, 21 April 2011. Available here: <http://www.telegraph.co.uk/news/health/news/8466996/Fearful-elderly-people-carry-anti-euthanasia-cards.html>

(should) explain to their terminally-ill patients. The trust between a patient and a doctor is eroded when doctors may be both healers and arrangers of death. The Hypocratic Oath, while not legally binding, has formed the basis for medical ethics for twenty-four centuries. It includes the following promise:

*I will give no deadly medicine to any one if asked, nor suggest any such counsel.*

The Declaration of Geneva, currently recited by graduating medical practitioners in Australia, contains the phrase “I will maintain the utmost respect for human life.” The ethical obligation of doctors to preserve the life of their patients is fundamental to the doctor-patient relationship.

In most cases the infirm and the elderly are vulnerable, they are unable to challenge advice, resist treatment or complain about neglect in the same way a healthy, young, strong person can. They depend on help; help from a source that they should be able to trust absolutely. Where doctors are invited to make moral, as well as medical, judgements about their patients’ prognosis – where euthanasia in fact becomes one of a number of ‘treatments’ – doctors will be required to canvas this procedure with the result that this trust is unavoidably undermined. The vulnerability of patients in such situations is profoundly increased.

*In Holland the medical profession has been corrupted by euthanasia ... many elderly and infirm people are inevitably frightened to approach doctors who first practise murder on request and then kill their own patients without consent. The Hippocratic oath wisely held that, if you cannot help, you do not harm. It will be difficult to trust any doctor who resiles from that most basic code of ethics.<sup>74</sup>*

Legislating to allow doctors to intentionally kill their patients understandably results in an increase in the fear among vulnerable population groups, particularly the elderly and disabled, of being killed against their will because a doctor judges that their life is not worth living. The fact that, in countries where euthanasia has been legalised, the elderly and the infirm regard hospital as a dangerous place results in a situation where those who need it most, may be most resistant to seeking medical help.

*Many elderly people in the Netherlands are so fearful of euthanasia that they carry cards around with them saying that they do not want it.<sup>75</sup>*

The corrosive effects of breaches of public trust are also illustrated in Elizabeth Bartell’s account of how the treatment her father received in hospital had a profound and lasting impression on her mother. Now 87-years-old, she was recently admitted to hospital insisting on resuscitation if she should die, believing this to be her best protection against doctors who might otherwise decide her life should end. Public trust in doctors is vital to the ability of the medical professions to help patients. The framework ensuring good governance among the medical profession is the responsibility of Parliament and cannot be delegated to any other profession.

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<sup>74</sup> Lord Allerton of Liverpool, House of Lords Hansard, UK Parliament, 6 May 1998, column 719.

<sup>75</sup> Martin Beckford, op. cit. This is also referred to in Lord McColl’s speech to the House of Lords, (House of Lords Hansard, UK Parliament, 6 May 1998, column 709).

## Can the State offer euthanasia with a clear conscience?

### Autonomous free choice requires patients have at least two good options

Advocates for euthanasia espouse this as the best way to achieve the greatest measure of autonomy for every individual. While ostensibly commendable, this creates problems in practice. If autonomy is regarded as an absolute right, this would logically require suicide to be available to anyone at any time for any reason. (Who is anyone else to say? Isn't all interference paternalism?) In weighing the competing claims to autonomy of those who wish to die and those who wish to live, the Legislative Assembly will inevitably fail to please everyone – the autonomy of some people will be violated in order to protect the autonomy of others.

The Assembly must therefore consider this question: is it a greater violation of autonomy to be killed against your will, or to be unassisted in your wish to commit suicide? It is absolutely certain that, if euthanasia is legalised, some people's lives will be ended without their consent, through mistakes or abuse; people will be killed when they otherwise would live. Even if the numbers were small, the violation of their autonomy would be absolute. Proponents of legalised assisted suicide must be willing to treat those lives ended through mistakes and abuse as "acceptable losses." ACL does not believe that any such losses are acceptable.

The numbers of those who wish to choose euthanasia may also be small, and the violation of their autonomy through preventing assistance with their suicide is qualitatively different. The government is not responsible for their suffering as it would be absolutely responsible for the deaths of others if the law were changed. It can, however, help those in need without increasing risk to the vulnerable by addressing their suffering in other ways. ACL urges the committee to consider improvements to palliative care, care for the elderly and education concerning the great benefits of such care, which will ultimately benefit all ACT residents. Autonomy or freedom of choice cannot be assured if patients are not provided with at least two good options. This means improvements to palliative care must precede any further discussion of euthanasia. Again, the example of Holland is salutary. In the House of Lords euthanasia debates, Lord Ashbourne commented that:

*one of the key problems with the practice of euthanasia in the Netherlands is the almost total lack of hospice care. There are only four hospices in the Netherlands and knowledge of palliative care is not widespread. I understand there is an excellent network of old people's homes, but these are not built on the hospice principle of symptom management, involving the physical, psychological, social and spiritual aspects of care.<sup>76</sup>*

Moreover, where assisted suicide is available, even the need to develop alternative policies to support the elderly and vulnerable may be obscured.

*You do not need hospices, good palliative care or relief from suffering or pain if you kill the patient instead.<sup>77</sup>*

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<sup>76</sup> House of Lords Hansard, UK Parliament, column 732.

<sup>77</sup> Lord Alton of Liverpool, House of Lords Hansard, UK Parliament, column 720.

If the vulnerable choose suicide simply because it looks like the best available option, this is not the same thing as 'free choice'. This is not an exercise in autonomy. This does not make us a more compassionate society.

### Universal access to palliative care must precede any discussion of euthanasia

Professor Diane Meier, quoted earlier, "believes that the angst propelling the [pro-euthanasia] movement would be diminished if patients had greater access to palliative care and if doctors were more attentive to their patients' psychological suffering."<sup>78</sup> Palliative care is a medical specialism addressing quality of life for patients with severe and terminal illnesses.

Overwhelmingly, medical practitioners both in Australia and internationally have voiced their opposition to euthanasia or physician assisted dying. The Victorian Parliamentary Committee considering euthanasia legislation has received petitions from 100 palliative care specialists, 101 oncologists and a group of geriatricians who collectively represent a significant proportion of medical specialists caring for the elderly and dying in Victoria. All are united in calling for the government to vote down the proposed legislation. Rather, they advocate for increased support and funding of the services needed by the patients in their care. The oncologists, for example, say this:

*Where cure of cancer is not possible, we seek optimal palliative care services to support and care for patients and their families at the end of life. Without easy access to quality palliative care, some may request physician assisted dying as they feel they have no other choice. This is especially so for people who live in rural, regional and remote areas and for people from culturally and linguistically diverse communities who have less access to palliative care services.*

*We are very disappointed that discussion of the Voluntary Assisted Dying Bill has dominated the agenda to improve end of life care in Victoria. We are dismayed that the multiple recommendations made by the Victorian Parliamentary Inquiry into End Of Life Choices (June 2016) to strengthen palliative care have not been actioned. Until this is addressed, discussing physician assisted dying is premature.<sup>79</sup>*

Addressing the Press Club earlier this year, Dr Michael Gannon, Head of the Australian Medical Association (AMA), explained the AMA's position on euthanasia very clearly:

*The AMA maintains its position that doctors should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of treatments that are of no medical benefit for a dying patient. That's not even euthanasia ...*

*We believe that governments must do all they can to improve end-of-life care for all Australians. They must properly resource palliative care services and advanced care planning, produce clear legislation to protect doctors who are providing good end-of-life care in accordance with the law ... The AMA recognises that good quality end-of-life care can alleviate pain and other sources of suffering for the overwhelming majority of people. There is already a lot that doctors can ethically and legally do to care for dying patients experiencing pain. This includes giving*

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<sup>78</sup> Rachel Aviv, op. cit.

<sup>79</sup> Attached in Appendix B.

*treatment with the intention of stopping pain and suffering, which may have the secondary effect of hastening death. I reiterated all of this yesterday in an address to 40 MPs in Victoria, imploring them to legislate protections according to this well-established doctrine of double effect. Bills in South Australia and Tasmania have been defeated. I encourage politicians in Victoria to put the horse before the cart and focus on the everyday issues for the majority of patients in end-of-life care ... There are medical, ethical and moral responsibilities at the heart of the doctor-patient relationship, and we all take them and our oath, the Declaration of Geneva, very seriously, indeed.<sup>80</sup>*

The evidence of opinion polls is often enlisted in support of lobbying efforts to legalise euthanasia. Advocates argue that legalisation is necessary to meet “modern community expectations”. In response to this argument it is important to note that polls also show community support for assisted suicide tails off sharply if the respondent is made aware that many doctors oppose it.<sup>81</sup> Peter Saunders, Campaign Director - Care Not Killing Alliance – UK provides compelling arguments for regarding such polls as a political device deployed by small, vocal lobby groups, to create the misleading impression that euthanasia is a burning political issue for the populace in general:

*lobby organisations like Dignity in Dying (formerly the Voluntary Euthanasia Society), [rely] on reflex opinion polls, high profile hard cases and celebrity endorsement rather than petitions, because if they tried the latter it would demonstrate just how weak their grass-roots support base really is.<sup>82</sup>*

### Does euthanasia ensure ‘a good death’?

In the public imagination, voluntary assisted suicide is seen as a guarantee of a quick, peaceful death. Parnis challenges this assumption in his report, pointing out that:

*In Oregon, a longitudinal study found 3% of assisted suicides had complications, including distressing symptoms. This may not seem as large number, but consider this against the claim made by ‘Dying with Dignity NSW’, that 4% of patients end their life in ‘extreme pain’. [Australian data puts this at 2%]<sup>83</sup> From this, Dying with Dignity have been lobbying for Assisted Dying in NSW. Why do advocates of Assisted Dying not admit that roughly the same percentage of people die in extreme discomfort with assisted dying/euthanasia? Why is one course ‘compassionate’ and the other not?<sup>84</sup>*

Parnis further notes that an analysis of cases from the Netherlands revealed that 7% of euthanasia patients “experienced unexpected side effects including regaining consciousness, vomiting, gasping

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<sup>80</sup> Michael Gannon, President of the Australian Medical Association, Address to the National Press Club, 23 August 2017.

<sup>81</sup> James Merlino, Victorian Legislative Assembly, Hansard, 17 October 2017.

<sup>82</sup> Peter Saunders, “Why opinion polls supporting euthanasia are inaccurate”, Euthanasia Prevention Coalition, 4 December 2012. (Available here: <http://alexschadenberg.blogspot.com.au/2012/12/why-opinion-polls-supporting-euthanasia.html>).

<sup>83</sup> See Palliative Care Specialist’s letter in Appendix A.

<sup>84</sup> Parnis, op.cit., p. 6.

for breath and seizures.<sup>85</sup> Research from Switzerland has found evidence of “post-traumatic stress disorder” and “complicated grief” in families after witnessing an assisted suicide.<sup>86</sup> In Oregon, David Pruitt took the lethal dose and sank into a coma only to wake up three days later.<sup>87</sup> The longest euthanasia death recorded in Oregon took 4 days and 8 hours to complete.<sup>88</sup>

If suffering is the problem, there is nothing to suggest that euthanasia offers more to the patient than can be delivered through good palliative care. In a recent letter to the Victorian Parliament, a group of palliative care specialists explained their role in assisting the terminally ill:

*As defined by the World Health Organisation and re-stated by the Australia and New Zealand Society of Palliative Medicine, the discipline of Palliative Care aims ‘to improve the quality of life of patients and families facing problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual’. Good end of life care, supported by the skills and expertise of palliative care professionals, also enhances a person’s choices, including the individual’s choice to refuse life-prolonging, or other medical treatments unacceptable to that individual.<sup>89</sup>*

These specialists further observe the public has been misled by false statements by advocates for euthanasia, including:

*[A]ssertions ... that Palliative Care doctors either cannot or will not relieve suffering and that ... euthanasia, is needed to address this.*

Rather, they offer the assurance that:

*“no one is abandoned and everyone can be supported and assisted in some way... All Australians should have the confidence that their care and support in their time of need will be defined by this approach, and not by the ill-advised and erroneous observations of those who are rushing to legalise assisted suicide.<sup>90</sup>*

The 2015 Auditor-General’s report *Palliative Care*, found that only a very small proportion of the Australians who recorded their preferred place of death (home), were actually able to die at home.<sup>91</sup> Rather, in Australia, dying is “more institutionalised than in the rest of the world”. Parnis quotes the Grattan Institute:

*Community and medical attitudes plus a lack of funds for formal community care mean that half of Australians die in hospital, and about a third in residential care.*

<sup>85</sup> J. Groenewoud et al, “Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands”, *New England Journal of Medicine*, vol. 342, 2000, pp. 551–556 (DOI: 10.1056/NEJM200002243420805).

<sup>86</sup> B. Wagner, J. Müller, and A. Maercker, “Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide”, *European Psychiatry*, vol. 27(7), 2012, pp. 542–546.

<sup>87</sup> “Oregon man wakes up after assisted-suicide attempt”, *Seattle Times*, 4 March 2005. (Available here: <http://www.seattletimes.com/nation-world/oregon-man-woke-up-after-assisted-suicide-attempt/>).

<sup>88</sup> “Oregon Death With Dignity Act: Data Summary 2016”, Oregon Public Health Division (2017), p. 11. (Available here: <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf>)

<sup>89</sup> See Appendix A.

<sup>90</sup> See Appendix A.

<sup>91</sup> “Palliative Care”, Victorian Auditor General Office, 2015, p. 17. (Available here: <https://www.audit.vic.gov.au/sites/default/files/20150415-Palliative-care.pdf>).

*Often they have impersonal, lingering and lonely death ... People want to die comfortably at home, supported by family and friends and effective services.*<sup>92</sup>

Although palliative care is effective and Australian Palliative care is currently ranked second in the world, this is not widely appreciated. Public education concerning the possibilities of palliative care, together with acknowledgement of the fallacy of claims that euthanasia guarantees a peaceful, pain-free death, is likely to considerably reduce public enthusiasm for the legalisation of assisted suicide.

### The economics of death may influence governments as well as families

No responsible government can afford to disregard its budget and the costs of palliative care are obviously considerable. In Canada, the benefits to the national budget of assisting suicide have already been grimly quantified in a 2016 report published in the Canadian Medical Association Journal. Doctor-hastened death, including life-ending drugs, can cost as little as \$25 per “patient”. By comparison, particularly in the final month of life, the medical costs of caring for the dying can increase dramatically. This report points out that physician-assisted dying has the advantage of enabling patients to “forgo this resource intensive period.” Even as the authors of this study protest that “neither patients nor physicians should consider costs when making the very personal decision to request, or provide, this intervention,” they announce the results of their gruesome calculations; assisted dying could save the Canadian government as much as \$139 million annually.<sup>93</sup>

In the same month this journal published articles on the following subjects:

- “Medical error and medical assistance in dying”;
- “Seniors and self-harm factor in the opioid crisis”;
- “Canada needs twice as many palliative specialists”.

It does not take a cynic to see how these issues are connected. Palliative care is expensive, provision is inadequate, seniors are self-harming under these circumstances and the inexpensive solution – delivering marvellous benefits to the incumbent government whose financial management will surely be applauded by a grateful electorate – is to facilitate euthanasia. It costs less than helping people.

The influence of economic considerations of helping the elderly are well recognised in discussions of elder abuse. The legislation allowing euthanasia in the Northern Territory had not been enacted long before it earned the nickname “The Early Inheritance Bill”. “Inheritance impatience” in adult children busy raising their own families, paying expensive mortgages in the midst of a housing shortage, negotiating the myriad of financial pressures afflicting young families was recently darkly satirised in Matt Day’s 2017 award-winning short film, *The Mother Situation*. Part of the reason for the success of this film is that it hits a nerve. It satirises a dark truth about human nature that is uncomfortable to acknowledge. If economic pressure can influence the decisions of children about their parents, how much more vulnerable are these individuals to financial calculations of the impersonal state?

The increased vulnerability of the elderly and disabled in times of national economic hardship have been noted overseas. Public attitudes to progressive illnesses, old age and disability harden in such

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<sup>92</sup> Ibid.

<sup>93</sup> Sharon Kelly, “Doctor-assisted suicide could save Canada up to \$139 million each year, Alberta study suggests”, *National Post*, 23 January 2017. Available at: <http://nationalpost.com/news/0124-na-assisted-dying>; Aaron J. Trachtenberg and Braden Manns, “Cost analysis of medical assistance in dying in Canada”, *Canadian medical Association Journal*, 23 January 2017, p. 189 (doi:10.1503/cmaj.160650)

times and hate crime figures in relation to vulnerable people increase dramatically. This only increases the dangers of facilitating suicide for those who most need help and support.

*It is not only dangerous for those who may see suicide as their only option, but can be tempting for those who would benefit from their absence.<sup>94</sup>*

If assisted suicide saves the public purse it is only because the price has been paid by those least able to protest the injustice of such a policy. We can do better. A just and compassionate society surely can find more respectful ways of dealing with suffering at the end of life than killing the suffering person. Baroness Campbell spoke for all those suffering disability and terminal illness when she represented this view to the House of Lords:

*Those of us who know what it is to live with a terminal condition are fearful the tide has already turned against us ... If I should ever seek death – and there have been times when my progressive condition challenges me – I want to guarantee that you are with me, supporting my continued life and its value. The last thing I want is for you to give up on me, especially when I need you most.<sup>95</sup>*

## Conclusion

It is regrettable that so much of this submission has concentrated on exploring the dangers of legislation that should be avoided, rather than looking at the many positive interventions that the Committee now has the opportunity to explore. If anything, this only affirms the importance of adhering to the first dictate of the Hypocritic Oath – “first, do no harm” – in considering end-of-life choices. Until positive interventions have been explored, funded and implemented; until an impregnable bulwark against the expansion of euthanasia laws by future governments can be established; until direct pressure and indirect pressure can be absolutely ruled out as motivation for suicide; until we can decide categorically which lives are worth living and which are not; until blue sky can be established between suicide for the terminally ill who want it and suicide for those who think they want it because of illness (even terminal illness), depression or both; until the economic savings of suicide can be shown to play no part in the thinking of governments or families; until palliative care is adequately funded and the benefits fully understood by all ACT residents; until fear of loss of dignity can be removed as a motivating factor for suicide, ACL submits that it is simply not safe to legalise assisted suicide.

Thank you for giving this submission your careful consideration.

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<sup>94</sup> John Bingham, “Recession has heightened euthanasia 'danger' to disabled and elderly, claims peer”, *The Telegraph*, 7 May 2014. Available here: <http://www.telegraph.co.uk/news/politics/10681076/Recession-has-heightened-euthanasia-danger-to-disabled-and-elderly-claims-peer.html>

<sup>95</sup> House of Lords Hansard, 7 July 2009, column 614. (Available here: <https://publications.parliament.uk/pa/ld200809/ldhansrd/text/90707-0008.htm>).

## Appendix A: An Open Letter to the Members of Parliament by Australian Palliative Care Professionals

We, the undersigned Australian Palliative Medicine professionals, do not support the introduction of medically assisted suicide or euthanasia in the states of Victoria and New South Wales. We are also writing to address claims made about Palliative Care by assisted suicide advocates, including Mr Andrew Denton, to the public and in the media. We do not intend this response as an attack on Mr Denton, and wish him well with a good recovery in his present illness.

We work every day with people who are seriously ill and dying, to support them and their families and carers when burdened by their illness or condition, and in their time of need.

Although the standard of Australian Palliative Care services, whether in the home or in the medical setting, are currently rated second in the world, this is not widely known in our community, and these services and our care are not well understood.

Our work is a good news story that should provide the public with great confidence.

Instead, in the current debates on euthanasia and assisted suicide, we frequently observe that public confidence in Palliative Care is being actively and deliberately undermined. Assertions include that Palliative Care doctors either cannot or will not relieve suffering and that assisted suicide, and in some cases euthanasia, is needed to address this.

This is simply false.

Current Australian data indicates that no more than 2 in every 100 Palliative Care patients would be in moderate or severe pain at the end of life. In these unusual cases where when all other methods of palliation for pain and other symptoms is inadequate, and if the patient agrees, palliative sedation therapy is available to provide adequate relief of suffering.

This is not just a 'pharmacological oblivion' as some have claimed. It is the careful management of pain and other severe symptoms through individualised medication plans at therapeutically recognised doses, and with dignified personal care, delivered by experienced doctors, nurses and allied health workers. Family and carers are also supported with emphasis on a holistic approach.

No one is abandoned and everyone can be assisted or supported in some way.

Mr Andrew Denton also claimed at the recent 'Communities in Control 2017 Conference' in Victoria, that because Catholic thinking holds that suffering can sometimes be of benefit to the person, Catholic Health Care service providers and Palliative Care professionals are deliberately under-medicating symptomatic patients at the end of life. This false assertion implies that professionals in these services are deciding that their patients should experience pain and suffering because it is somehow good for them.

It is contrary to fact that any Palliative Care service or its employees, of any faith or secular belief, would behave this way. The approach to Palliative Care across all Australian and New Zealand services is held to professional standards, with rigorous and transparent quality control and benchmarking, contributing to our high world ranking.

One has to question the targeting of services and professionals providing the majority of the care and support of those who are terminally or chronically ill, and their families.

Ironically, Mr Denton and others simultaneously claim that Palliative Medicine sets out to end peoples' lives in the guise of giving pain relief. Both claims are false. Research has shown beyond doubt that therapeutic doses of opioid medications and sedatives in palliative care settings do not shorten life. The often-repeated claim that Palliative Care professionals purposely shorten the lives of patients with medication and other practices is untrue, and risks discouraging terminally ill and vulnerable patients from seeking the assistance of Palliative Care, or from taking the very medication which would ease their pain.

As defined by the World Health Organisation and re-stated by the Australia and New Zealand Society of Palliative Medicine, the discipline of Palliative Care aims "to improve the quality of life of patients and families facing problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual." Good end of life care, supported by the skills and expertise of Palliative Care professionals, also enhances a person's choices, including the individual's choice to refuse life-prolonging, or other medical treatments unacceptable to that individual.

All Australians should have the confidence that their care and support in their time of need will be defined by this approach, and not by the ill-advised and erroneous observations of those who are rushing to legalise assisted suicide.

For the sake of public confidence, we ask that all sides of the current debate respect the role of Palliative Care services and the dedication and competence of all the professionals that staff them.

If assisted suicide or euthanasia laws are ever considered by our parliaments, that consideration should not be based on the false belief that we cannot assist or support those with pain and suffering in a professional and ethical manner.

If there is a problem facing Palliative Care in Australia it is that access to high quality services is not yet universal. We therefore warmly welcome the commitment of the New South Wales government to provide an additional \$100M to the sector focussing on rural and regional service delivery. We call on the Victorian Government to support the call by Palliative Care Victoria for \$65M recurring funding to assist the service to provide care for those in need.

It would be unethical for any state jurisdiction in Australia to move to legalise for assisted suicide or euthanasia whilst many ill, aged and disabled Australians cannot yet access the support that they need. Such a move would not enhance choice, but instead reduce choice around the care and support for those in real need.

We call all Victorian legislators to recommit to Palliative Care and the other services needed to better benefit all Victorians, and not to let others' agendas undermine more pressing Health Care and Community Service priorities.

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## Appendix B: Open Letter to Victorian Members of Parliament by Victorian Oncologists

August 2017

Dear Honourable Victorian Parliamentary Representatives,

We, the undersigned 100 Victorian Oncologists (cancer specialists), request that you vote AGAINST the proposed Victorian Assisted Dying Bill 2017.

As 80% of those who access physician assisted dying legally overseas have cancer, we feel our perspective on this issue should be heard.

We add our voices to the 100 palliative care specialists who have already corresponded with you requesting that you oppose the passage of this bill.

We collectively represent a significant proportion of the oncology workforce in the state of Victoria.

We do not believe that it is possible to draft assisted dying laws that have adequate safeguards to protect vulnerable populations, especially those with incurable cancer, progressive neurological illness, the aged and disabled. These groups of people experience high rates of depression and isolation. The risks that such legislation poses for the majority of these outweigh any benefits for the few in our opinion.

Physician assisted dying places people at risk of coercion that is both active and passive. As a consequence of assisted dying laws, society re-assesses the value of life; and the individual is taught to devalue their own life. Those with serious illness may perceive that they are a burden on society or their carers and come to feel that assisted dying is appropriate for them.

Assisted dying laws are easily challenged from a human rights and equality perspective. Indications over time will be extended beyond adults with terminal illness, to those with mental illness alone, dementia, disability, children and the healthy elderly who have “completed lives”. In Oregon USA in June 2017 the senate debated a bill that would allow demented patients and others with “mental incompetence” to be starved to death. Oregon is not a lead that we wish to follow.

Physician assisted death is not, by definition, medical treatment. It is not palliative care. We as doctors and medical specialists do not want to intentionally end the lives of our patients, or provide them with the direct means to do so. Assisted suicide is in conflict with the basic ethical principles and integrity of medical practice and undermines trust in the medical profession. We strive to eliminate suffering but not the sufferers themselves.

Where cure of cancer is not possible, we seek optimal palliative care services to support and care for patients and their families at the end of life. Without easy access to quality palliative care, some may request physician assisted dying as they feel they have no other choice. This is especially so for people who live in rural, regional and remote areas and for people from culturally and linguistically diverse communities who have less access to palliative care services.

We are very disappointed that discussion of the Voluntary Assisted Dying Bill has dominated the agenda to improve end of life care in Victoria. We are dismayed that the multiple recommendations made by the Victorian Parliamentary Inquiry into End Of Life Choices (June 2016) to strengthen palliative care have not been actioned. Until this is addressed, discussing physician assisted dying is premature.

In June 2017 the NSW government allocated an extra \$100 million to fund palliative care services over 4 years, particularly to provide extra funds for community palliative care services and for rural and regional NSW. Need in these same areas has been identified by the Victorian End of Life Choices report. Palliative Care Victoria's figures demonstrate that an extra \$65 million per year is required to meet deficits and adequately cover future cost projections in these areas. Such funding is essential if dying Victorians are to be adequately cared for in their homes with adequate supports for both them and their families.

**We call for improved funding of palliative care services in Victoria, for the benefit of all Victorians, but especially those who live with incurable cancer and their families.**

This will go some way to ensuring that fear of suffering does not dictate a person's final hours, nor the memories their loved ones will carry throughout their own lives.

The United Kingdom parliament resoundingly rejected an Assisted Dying bill in 2015 as there is no "safe system" and we urge the Victorian parliament to do the same.

Yours sincerely,

The undersigned 100 Victorian Cancer specialists.

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## Appendix C: Open Letter to Victorian Members of Parliament by Victorian Geriatricians

Parliament of Victoria  
Spring Street  
Melbourne Victoria 3000

3<sup>rd</sup> October 2017

Dear Victorian Parliamentary Representative,

We, the undersigned Victorian Geriatricians request that you vote AGAINST the proposed Victorian Assisted Dying Bill 2017.

As we deal with the frail, elderly and vulnerable in our community we feel our perspective on this issue should be heard.

We add our voices to the 100 Palliative Care Specialists and the 101 Oncologists who have already corresponded with you requesting that you oppose the passage of this bill.

We collectively represent a significant proportion of the Geriatric Medicine workforce in the state of Victoria. The position of the Victorian Branch of the Geriatric Medicine society is in accordance with the stated position of the Australia and New Zealand Society for Geriatric Medicine (ANZSGM) as laid out in the Position Statement on Euthanasia, Physician-Assisted Suicide and End of Life Care endorsed by the Society in 2015.

We do not believe that it is possible to draft assisted dying laws that have adequate safeguards to protect vulnerable populations, especially those with incurable cancer, progressive neurological illness, the aged and disabled. These groups of people experience high rates of depression and isolation. The risks that such legislation poses for the majority of these outweigh any benefits for the few in our opinion.

Physician assisted dying places people at risk of coercion that is both active and passive. As a consequence of assisted dying laws, society re-assesses the value of life; and the individual is taught to devalue their own life. Those with serious illness may perceive that they are a burden on society or their carers and come to feel that assisted dying is appropriate for them. We are also concerned about being placed in the position of having to assess the capacity of patients to make this decision.

Assisted dying laws can be challenged from a human rights and equality perspective. Indications over time will be extended beyond adults with terminal illness, to those with mental illness alone, dementia, disability, children and the healthy elderly who have "completed lives".

Physician assisted death is not part of palliative care practice. We as doctors and medical specialists do not want to intentionally end the lives of our patients, or provide them with the direct means to do so. Assisted suicide is in conflict with the basic ethical principles and integrity of medical practice and undermines trust in the medical profession.

Where curative treatment is not possible, we seek optimal palliative care services to support and care for patients and their families at the end of life. Without easy access to quality palliative care, some may request physician assisted dying as they feel they have no other choice. This is especially so for

people who live in rural, regional and remote areas and for people from culturally and linguistically diverse communities who have less access to palliative care services.

We are very disappointed that discussion of the Voluntary Assisted Dying Bill has dominated the agenda to improve end of life care in Victoria. We are dismayed that the multiple recommendations made by the Victorian Parliamentary Inquiry into End of Life Choices (June 2016) to strengthen palliative care have not yet been actioned. Until this is addressed, discussing physician assisted dying is premature.

In June 2017 the NSW government allocated an extra \$100 million to fund palliative care services over 4 years, particularly to provide extra funds for community palliative care services and for rural and regional NSW. Need in these same areas has been identified by the Victorian End of Life Choices report. Palliative Care Victoria's figures demonstrate that an extra \$65 million per year is required to meet deficits and adequately cover future cost projections in these areas. Such funding is essential if dying Victorians are to be adequately cared for in their homes with adequate supports for both them and their families.

We call for improved funding of palliative care services in Victoria, for the benefit of all Victorians. This will go some way to ensuring that fear of suffering does not dictate a person's final hours, nor the memories that their loved ones will carry throughout their own lives.

The United Kingdom parliament resoundingly rejected an Assisted Dying bill in 2015 as there is no "safe system" and we urge the Victorian Parliament to do the same.

Yours sincerely,

The undersigned Victorian Geriatric Medicine specialists.

The listed signatories support this statement as individual health professionals and not as representatives of any hospital or other organisation with which they are associated.

Dr Olivia Gobbo, Geriatrician, Monash Health

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[Appendix D: Voluntary Assisted Death - Parnis Report 2017](#)

Please see pdf filed accompanying this submission.