Submission to the

Joint Committee on End of life Choices of the Parliament of South Australia

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for the Australian Care Alliance

This submission will address the following terms of reference:

> *The current legal framework, relevant reports and materials in other Australian states and territories and overseas jurisdictions, including the Victorian and Western Australian Parliamentary Inquiries into end-of-life choices, Victoria's Voluntary Assisted Dying Act (2017) and implementation of the associated reform*

The Australian Care Alliance was formed in March 2018 by health professionals, lawyers and community activists who had worked together informally to oppose the passage of the Voluntary Assisted Dying Bill 2017 through the Parliament of Victoria.

It is the considered position of the Australian Care Alliance, based on all the available evidence, that none of the jurisdictions that have legalised euthanasia and/or assisted suicide, including Victoria, have succeeded in establishing a safe assisted suicide/euthanasia framework.

This submission maintains that there are eleven categories of wrongful deaths that will inevitably and unavoidably occur under any scheme which legalises assisted suicide and/or euthanasia.

These categories of wrongful death are:

1. a wrong diagnosis
2. a wrong prognosis
3. unaware of or unable to access effective treatment
4. no access to palliative care

5. denied funding for medical treatment
6. mentally ill at risk
7. “better off dead” than disabled
8. bullying or coercion
9. social contagion of suicide.
10. killed without request or while resisting
11. Inhumane deaths by assisted suicide or euthanasia that are neither not a rapid nor peaceful.

Therefore, the Australian Care Alliance believes that any law permitting assisted suicide or euthanasia is inherently unsafe and unjust.

The better and wiser approach is to work towards ensuring that:

- all South Australians have access to best practice palliative care – especially by improving palliative care expertise among medical and nursing professionals generally so that is brought up to the standard of expert palliative care units, which manage terminal care difficulties quite adequately;
- disabled persons have equitable access to health care and are supported to live their lives to the full as valued members of the community;
- suicide prevention strategies and services offer hope to any South Australian with suicidal ideation, including identifying those with declining physical health and those faced with the diagnosis of a terminal or chronic illness or with a newly acquired disability as at risk groups for suicide and developing specific measures to prevent suicides in this at risk group; and
- elderly Australians are protected from all forms of elder abuse, including any pressure to see themselves as an unwanted burden.

Contents

THREE PRELIMINARY CONSIDERATIONS

Calling things by their proper names

Firstly, it is unhelpful and obfuscating to use neologisms such as "voluntary assisted dying". The precise acts for which legalisation is to be considered are best described by their proper names: assisted suicide and euthanasia.

Assisted suicide in this context means the act of prescribing and supplying a lethal poison to a person with the intention that the person will subsequently ingest the poison so as to cause his or her death.

Euthanasia in this context means a person, usually a physician, administering a lethal poison to a person with the intention of bringing about the person's death.

Legalising these acts, albeit subject to eligibility criteria and procedural requirements, necessitates changing the criminal law on assisted suicide and murder.

Euthanasia is currently unlawful and would constitute the crime of murder and under Section11 of the *Criminal Law Consolidation Act 1935* be subject to a penalty of life imprisonment.

Making it lawful for a physician to administer a lethal poison to a person in order to intentionally bring about the person's death would require creating an exception to the crime of murder.

Assisted suicide would, under Section 13A (5)-(6) of the *Criminal Law Consolidation Act 1935* constitute the crime of aiding or abetting a person commit suicide and be subject to a penalty of 14 years imprisonment.

Making it lawful for a physician to prescribe a lethal poison and to instruct a person in how to ingest that poison so as to cause the person's death requires limiting the operation of this section so that, in some cases, it would be lawful to aid and abet suicide.

Obviously any proposal to create exceptions to the laws prohibiting murder and aiding or abetting suicide should be subject to the most careful scrutiny.

Is it just about a very small number of people who are imminently dying and are experiencing unrelievable pain?

There is a telling disconnect between the focus of assisted suicide and euthanasia laws when they are being proposed and after they have been implemented.

During the proposal phase the focus is almost universally on an alleged group of hard cases, small in number, who, it is said, are suffering unbearable physical pain or other physical symptoms that cannot be relieved by even the best palliative care. This claim is based

largely on anecdotal evidence, often from experiences some decades ago before recent developments in palliative care.

After implementation it becomes clearer that the real focus is on autonomy – an alleged right to assistance to die at a time of one's own choosing for any reason.

No actual legislative scheme anywhere in the world has in practice been limited to persons with allegedly unrelievable pain or other physical suffering.

This is because such schemes (e.g. Belgium, the Netherlands, Victoria) either refer to "suffering", an entirely subjective term which can include existential and social factors such as the meaningfulness of one's life or the sense of being a burden on family, or have no requirement related to pain or suffering at all (Oregon and other US jurisdictions).

What is the proper test for a scheme that allows euthanasia and assisted suicide but has necessary safeguards to protect vulnerable persons?

Some proponents of legalising assisted suicide or euthanasia admit that it is the case that wrongful deaths will occur.

Henry Marsh, a noted British neurosurgeon and champion of assisted suicide, famously said,

"*Even if a few grannies are bullied into committing suicide, isn't that a price worth paying so that all these other people can die with dignity*?"[1]

This is the question that anyone considering this issue needs to ask.

The proper tests for a law permitting assisted suicide or euthanasia are the ones that are usually applied to any proposal to reintroduce the death penalty:

"*Can we craft a law that will ensure there will not be even one wrongful death*?"

"*Can we ensure that any deaths under this law are humane - that is both rapid and peaceful*?"

The remainder of this submission will address these tests.

ELEVEN CATEGORIES OF WRONGFUL DEATH

The Australian Care Alliance has identified eleven categories of wrongful death that could result from any scheme legalising assisted suicide and/or euthanasia.

[1] https://www.medscape.com/viewarticle/879187 [Free registration required to view article]

The onus is on proponents of such schemes to demonstrate how such wrongful deaths can be guaranteed not to occur under the scheme that they propose.

A wrong diagnosis

If a person dies by assisted suicide or euthanasia following **a mistaken diagnosis that the person has a terminal illness** then that is a wrongful death – with no remedy.

The only way to ensure that there are no such wrongful deaths would be to ensure that physicians never make mistakes in diagnoses. Unfortunately this is not achievable.

According to evidence given by Dr Stephen Child, Chair of the New Zealand Medical Association to the New Zealand parliamentary inquiry into the practice of euthanasia:

"*On diagnosis, 10 to 15 per cent of autopsies show that the diagnosis was incorrect. Three per cent of diagnoses of cancer are incorrect*".

Dr Child said this scope for error was too large, when weighed against the outcome. "*This is an irreversible decision in which the consequences are final*." [2]

Ten per cent of cases in Australia are misdiagnosed according to Peter McClennan, chief executive at Best Doctors.[3]

Two examples illustrate this category of wrongful death:

An August 2018 report on Missouri resident Pasquale Michael Fatino, aged 52, who is suing three doctors at his former primary care clinic for a misdiagnosis of terminal cancer that caused him and his family unnecessary pain and suffering last year, illustrates that such mistakes do happen.[4] If assisted suicide had been legal in Missouri, Mr Fatino may have been dead before the misdiagnosis came to light.

This happened to retired Italian magistrate Pietro D'Amico, aged 62, whose family insisted on an autopsy which found that he did not have a terminal illness at all, despite being given such a diagnosis by both Italian and Swiss doctors prior to undergoing assisted suicide in Switzerland.[5]

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[2] http://www.stuff.co.nz/national/politics/84252580/euthanasia-toofinal-when-the-risk-of-error-is-to-great--doctors

[3] https://amp.afr.com/business/insurance/insurance-companies/mlc-life-to-expand-best-doctors-service-20170827-gy4zfk

[4] https://www.kansascity.com/news/business/health-care/article216764080.html

[5] https://www.thelocal.ch/20130711/assisted-suicide-in-question-after-botched-diagnosis

Simply having two doctors diagnose that a person has a terminal illness is an illusory safeguard. There is no remedy for a wrongful death by assisted suicide based on misdiagnosis.

How many wrongful deaths from assisted suicide following misdiagnosis of a terminal illness are too many?

A wrong prognosis

If a person dies by assisted suicide or euthanasia **after being told in error that they have less than six months to live when they may have many years of life ahead of them** then that is a wrongful death – with no remedy.

This applies regardless of whether the legislation permitting assisted suicide or euthanasia sets a minimum time to expected death (six months in Victoria, Oregon and other US jurisdictions) or not (Belgium, the Netherlands, Canada).

A survey of the medical literature on prognosis indicates that **an accurate prognosis is notoriously difficult to make**.

A study on the accuracy of prognoses in oncology found that "*discrimination between patients who would survive for one year and those who would not was very poor*".[6]

Another paper describes doctors' ability at predicting survival at 1 year as "*only slightly better than a random guess*".[7]

A study published in 2000 in the British Medical Journal found that physicians only made accurate (within 33% margin either way) prognoses in 20% of cases for terminally ill patients.

Significantly for the use of a prognosis in allowing access to assisted suicide or euthanasia is the finding that in 17% of cases physicians were overly pessimistic in their prognosis by more than 33% and out by a factor of 2 in 11.3% of cases.[8]

In other words, perhaps **more than one in ten people given a prognosis of 12 months to live may live for 2 years or more**.

[6] https://www.sciencedirect.com/science/article/pii/S0895435696003162

[7] http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0161407

[8] http://www.bmj.com/content/bmj/320/7233/469.full.pdf

Evidence from the states of Oregon and Washington, where assisted suicide is legal, demonstrates conclusively that physicians make significant errors in determining a prognosis of less than six months to live in the context of a request to access assisted suicide.

Although the law in Washington State specifies that only persons who have a disease that will "produce death within six months" may request lethal doses of medication from a physician, the data shows that in each year between 5% and 17% of those who die after requesting a lethal dose do so more than 25 weeks later with one person in 2012 dying nearly 3 years (150 weeks) later, one person in 2015 dying nearly two years later (95 weeks) and one person in 2016 dying more than two years (112 weeks) later.[9]

In Oregon in 2018 one person ingested lethal medication 807 days (2 years 2 ½ months) after the initial request for the lethal prescription was made. The longest duration between initial request and ingestion recorded is 1009 days (that is 2 years and 9 months).[10] Evidently in these cases the prognosis was wildly inaccurate.

Dr Kenneth Stevens has written about his experience of how the prognosis of six months to live works in practice under Oregon's law:

> *Oregon's assisted-suicide law applies to patients predicted to have less than six months to live. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live. This was based on her not being treated for cancer.*
>
> *At our first meeting, Jeanette told me that she did not want to be treated, and that she wanted to opt for what our law allowed – to kill herself with a lethal dose of barbiturates.*
>
> *I did not and do not believe in assisted suicide. I informed her that her cancer was treatable and that her prospects were good. But she wanted "the pills." She had made up her mind, but she continued to see me.*
>
> *On the third or fourth visit, I asked her about her family and learned that she had a son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated, and her cancer was cured.*
>
> *Five years later she saw me in a restaurant and said, "Dr. Stevens, you saved my life!"*

[9] Washington State Department of Health, *Death with Dignity Act Reports,* 2009-2017 available at: http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData

[10] Oregon Public Health Division, *Oregon Death With Dignity Act: 2018 Data Summary, Table 1,* p.13 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

For her, the mere presence of legal assisted suicide had steered her to suicide.[11]

Jeanette Stevens is still alive today and has enjoyed 19 years of life that would have been taken from her if she had not been talked out of pursuing assisted suicide under Oregon's fatally flawed law.

How many wrongful deaths from errors in prognosis is too many?

Unaware of or unable to access effective treatment

Some assisted suicide or euthanasia laws purport to provide an additional safeguard by requiring at least one doctor with relevant specialist experience to assess the person and inform them of all relevant information about the person's condition.

However, despite such provisions the evidence from jurisdictions which have legalised assisted suicide or euthanasia shows that **some people miss out on treatment that could have helped them and instead suffer a wrongful death** by assisted suicide or euthanasia.

Out of the four deaths under the Northern Territory's short lived euthanasia laws one of those who died by euthanasia would have benefited from radiotherapy or strontium but neither of these was available in the Northern Territory. Another could have been helped by stenting for obstructive jaundice or the management of bowel obstruction. However, Dr Nitschke who euthanased this person, admitted to having "*limited experience, not having been involved in the care for the dying before becoming involved with the" euthanasia law.*[12]

Similar examples are found in other jurisdiction such as in case 15 reported in the 2011 annual report of the Netherlands Regional Euthanasia Review Committees which conclude that the attending physician failed to achieve an accurate diagnosis of the woman's back pain and only prescribed limited pain relief medication. Consequently it could not be said that the woman's pain was definitively unrelievable. Of course the woman can get no relief from this finding of error on the part of the doctor who failed her and then euthanased her as she is already dead by euthanasia.[13]

No legal framework permitting assisted suicide or euthanasia has yet been established which effectively ensures that all persons being killed or helped to commit suicide are properly informed about all treatment options available for their condition. People will inevitably be killed or helped to commit suicide who could have benefited from treatment.

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[11] Kenneth Stevens "Doctor helped patient with cancer choose life over assisted suicide", *Missoulian,* 27 November 2012, http://missoulian.com/news/opinion/mailbag/doctor-helped-patient-with-cancer-choose-life-over-assisted-suicide/article_63e092dc-37e5-11e2-ae61-001a4bcf887a.html

[12] http://www.healthprofessionalssayno.info/uploads/1/0/9/2/109258189/seven_deaths_in_darwin_case_studies_unde.pdf

[13] http://www.euthanasiecommissie.nl/Images/RTE.JV2011.ENGELS.DEF_tcm52-33587.PDF

No access to palliative care

In Oregon in 2018 in 17.9% of cases (nearly one in six) the attending physician reports that he or she does not know whether or not the person who has died after ingesting lethal medication which the physician prescribed had any concern about inadequate pain control at the end of life.

ORS 127.815 sets out as one of the responsibilities of an attending physician under the Death With Dignity Act a duty "*To ensure that the patient is making an informed decision, inform the patient of the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control*".

Before lethal medication is prescribed a person must sign a request form affirming, among other things, "*I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control*."

But if the attending physician has not asked the person about any concerns about inadequate pain control at the end of life how can the attending physician possibly have properly informed the person about feasible alternatives to ingesting lethal medication such as "comfort care, hospice care and pain control"?

In a further 25.6% of cases from 2018 the attending physician reported that concern about inadequate pain control at the end of life was factor in a person's request. Earlier annual reports noted that "*Patients discussing concern about inadequate pain control with their physicians were not necessarily experiencing pain*."[14]

Palliative Care Victoria has stated:

Achieving the effective management of pain and other symptoms is a high priority in the care of people with a life limiting illness and people who are dying. Where these symptoms are not readily alleviated by general health and care services, a referral to access the specialised expertise of palliative care services should be made. In most cases, specialist palliative care teams are able to address the person's physical pain and other symptoms and to respond to their psycho-social, emotional, spiritual and cultural needs so that they are able to live and die well with dignity. However, a small minority of patients experience refractory symptoms such as agitated delirium, difficulties breathing, pain and convulsions.

In these rare cases palliative sedation therapy is available to provide adequate relief of suffering.

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14 http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year6.pdf

[T]he level of sedation used should be the lowest necessary to provide adequate relief of suffering: "The doses of medications should be increased or reduced gradually to a level at which suffering is palliated with a minimum suppression of the consciousness levels and undesirable effects, with documentation of the reason for changes and response to such manoeuvres." Only under exceptional circumstances is deep and continuous sedation required from initiation of palliative sedation therapy.[15]

No case for legalising assisted suicide can properly be made on the basis that this is the only possible response to people facing unrelievable pain. Every South Australian deserves access to best practice palliative care which can alleviate pain, including using palliative sedation as a last resort.

Wrongful deaths by assisted suicide or euthanasia occur when people are not fully informed about palliative care by actual palliative care specialists and request assisted suicide or euthanasia due to misplaced fears about pain or other physical symptoms.

Denied funding for medical treatment

People who are denied funding for medical treatment by medical insurers or the public health system but are offered funding for assisted suicide or euthanasia, as has happened in Oregon, California and Canada are at risk of wrongful deaths either by being denied needed treatment or bullied into agreeing to assisted suicide.

In Oregon in two notorious cases, those of Barbara Wagner[16]and Randy Stroup,[17] the Oregon Health Plan informed a patient by letter that the particular cancer treatment recommended by their physicians was not covered by the Plan but that the cost of a lethal prescription to end their life would be covered.

In California Stephanie Packer, a wife and mother of four who was diagnosed with a terminal form of scleroderma, reports that "when the [assisted suicide] law was passed, it was a week later I received a letter in the mail saying they [her insurance company] were going to deny coverage for the chemotherapy that we were asking for." She called her insurance company to find out why her coverage had been denied. On the call, she also asked whether suicide pills were covered under her plan. She was told "Yes, we do provide that to our patients, and you would only have to pay $1.20 for the [lethal] medication."

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15 http://www.parliament.vic.gov.au/images/stories/committees/lsic/Submissions/Submission_236_-_Palliative_Care_Victoria.pdf

16 https://abcnews.go.com/Health/story?id=5517492

17 http://www.foxnews.com/story/2008/07/28/oregon-offers-terminal-patients-doctor-assisted-suicide-instead-medical-care.html

In Canada Roger Foley, who has a crippling brain disease, has been seeking support to live at home. He is currently in an Ontario hospital that is threatening to start charging him $1,800 a day. The hospital has told Roger that his other option is euthanasia or assisted suicide under Canada's medical assistance in dying law.[18]

Additionally concerns about the financial cost of treatment or care may be an open or hidden motivator for requesting assisted suicide or euthanasia.

Of those who died from ingesting a lethal dose of medication in Oregon in 2018, more than one in twenty (5.35%) mentioned the *"financial implications of treatment"* as a consideration. While this percentage is relatively small it is appalling that since 1998 fifty seven (57) Oregonians have died from a lethal prescription after expressing concerns about the financial implications of treatment.[19]

In more than one out of four cases (26.8%) in 2018 the attending physician simply did not bother to find out whether or not a concern about the cost of treatment or care was underlying the request for lethal medication.

How can an attending physician form a valid view that a request for lethal medication is being made "voluntarily" if a possible concern about the financial costs of treatment or care is never explored with the person?

Mentally ill at risk of wrongful death

People with a mental illness are at risk of wrongful death under any law authorising assisted suicide or euthanasia.

In the Netherlands and Belgium mental illness is seen as a condition for which euthanasia or assisted suicide is increasingly considered to be an appropriate response.

In Belgium there were 201 cases of euthanasia for psychiatric disorders between 2014 and 2017. This included 25 cases of people under 40 being killed by euthanasia. In relation to these troubled young people the Commission observes:

> *In the group of patients under 40, it is mainly personality and behavioral disorders. All these patients have been treated for many years, both outpatient and residential. There has always been talk of intractable suffering. For this type of disorder, serious*

[18] https://www.australiancarealliance.org.au/canada_assisted_suicide_not_assisted_living

[19] Oregon Public Health Division, *Oregon Death With Dignity Act: 2018 Data Summary, Table 1,* p.12 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

psychological trauma at a very young age has been mentioned several times, such as domestic violence, psychological neglect or sexual abuse.[20]

Belgium is treating the victims of child abuse by domestic violence, neglect and sexual abuse by killing them!!

In Oregon and Washington State where the laws provide for *optional referral* for psychiatric assessment the evidence shows that the gatekeeping medical practitioners very seldom refer and that this results in persons with *treatable clinical depression* being wrongfully assisted to commit suicide.

Research by Linda Ganzini has established that one in six people who died under Oregon's law had clinical depression.[21]

Depression is supposed to be screened for under the Act. However, in 2018 only 3 out of 168 people (1.78%) who died under the Oregon law were referred by the prescribing doctor for a psychiatric evaluation before writing a script for a lethal substance.[22]

This means it is likely that in Oregon in 2018 alone about 25 people with clinical depression were prescribed and took a lethal poison without being referred for a psychiatric evaluation.

In the Northern Territory, where euthanasia was legal from July 1996-March 1997, and compulsory screening by a psychiatrist was required, there was a failure to adequately identify depression, demoralization or other psychiatric issues which may have been treatable in all four cases of persons killed under that regime.

During the nine month period in which the ROTI Act was in effect and under its provisions, four people were assisted to terminate their lives by Dr Philip Nitschke.

Case studies on these four deaths have been published.[23] The principal author of this paper is Professor David Kissane, who is a consultant psychiatrist and professor of palliative medicine. Philip Nitschke is a co-author of the paper.

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[20] Commission fédérale de Contrôle et d'Évaluation de l'Euthanasie, https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/8_rapport-euthanasie_2016-2017-fr.pdf

[21] Linda Ganzini et al., "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey", *BMJ* 2008;337:a1682, http://www.bmj.com/content/bmj/337/bmj.a1682.full.pdf

[22] Oregon Public Health Division, *Oregon Death With Dignity Act: 2018 Data Summary, Table 1,* p.11 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

The case studies examine how the conditions required by the ROTI Act were met. Cases numbered 3, 4, 5 and 6 in this paper refer to those cases which ended with the person's life being terminated with the assistance of Dr Philip Nitschke.

From the case histories, it is apparent that cases 3 and 4 each had depressive symptoms.

In case 3, the patient had received "*counselling and anti-depressant medication for several years*". He spoke of feeling sometimes so suicidal that "*if he had a gun he would have used it*". He had outbursts in which he would "*yell and scream, as intolerant as hell*" and he "*wept frequently*".

Neither the patient's adult sons nor the members of the community palliative care team who were caring for him were told he was being assessed for euthanasia. "*A psychiatrist from another state certified that no treatable clinical depression was present*."

In case 4, "*the psychiatrist noted that the patient showed reduced reactivity to her surroundings, lowered mood, hopelessness, resignation about her future, and a desire to die. He judged her depression consistent with her medical condition, adding that side-effects of her antidepressant medication, dozepin, may limit further increase in dose*."

Kissane comments that "*case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management*." While Dr Nitschke "*judged this patient as unlikely to respond to further treatment*", Kissane, comments that "*nonetheless, continued psychiatric care seemed warranted – a psychiatrist can have an active therapeutic role in ameliorating suffering rather than being used only as a gatekeeper to euthanasia*".

In case 6 a key factor seemed to be the patient's distress at "*having witnessed*" the death of her sister who also had breast cancer, "*particularly the indignity of double incontinence*". She "*feared she would die in a similar manner*". She "*was also concerned about being a burden to her children, although her daughters were trained nurses*".

Kissane noted that "*fatigue, frailty, depression and other symptoms*" – not pain – were the prominent concerns of those who received euthanasia. He observed that "*palliative care facilities were underdeveloped in the Northern Territory, and patients in our study needed palliative care… There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care*."

Further concerns are raised by the report on case 5. Dr Nitschke reported that "*on this occasion the psychiatrist phoned within 20 min, saying that this case was straightforward*". This assessment took place on the day on which euthanasia was planned. This case involved an elderly, unmarried man who had migrated from England and had no relatives in Australia. Dr Nitschke recalled "*his sadness over the man's loneliness and isolation as he administered euthanasia*". Dr Nitschke has since revealed in testimony to a Senate committee, that he

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23 https://d3n8a8pro7vhmx.cloudfront.net/australiancarealliance/pages/95/attachments/original/1553489155/seven_deaths_in_darwin_case_studies_unde.pdf?1553489155

personally paid for this psychiatric consultation and that it in fact took less than 20 minutes.[24]

There is no model from any jurisdiction that has legalised assisted suicide and/or euthanasia for adequately ensuring that no person who is assisted to commit suicide or killed directly by euthanasia is suffering from treatable clinical depression or other forms of mental illness that may affect the capacity to form a competent, settled, determination to die by assisted suicide or euthanasia.

Jurisdictions, like Oregon, that provide for optional referral for psychiatric assessment manifestly fail to identify all cases of clinical depression.

The only jurisdiction which has required a psychiatric assessment for each case of euthanasia was the Northern Territory. However, this system signally failed to adequately identify depression, demoralization or other psychiatric issues which may have been treatable in all four cases of persons killed by former doctor Philip Nitschke under the Rights of the Terminally Ill Act 1995 (NT).

Compulsory referral to a psychiatrist, who may have never seen the person before, for a single brief assessment of whether the person's decision making capacity about assisted suicide or euthanasia is affected by depression or other psychiatric factors is clearly an inadequate safeguard and will not make assisted suicide "safe".

Better off dead than disabled

Due to social prejudice and ignorance which is widespread including among physicians and other health professionals, people with disabilities are often considered to be "better off dead".

This puts them at additional risk of wrongful death under any scheme that legalises euthanasia or assisted suicide.

In the Netherlands and Belgium disability – both physical and intellectual – is accepted as a reason to euthanase a person.

In Oregon the **five main reasons** given for requesting assisted suicide **all relate to disability** issues.

These are concerns about decreasing ability to participate in activities that made life enjoyable (90.5%), loss of autonomy (91.7%), loss of dignity (66.7%), physical or emotional

[24] https://www.aph.gov.au/~/media/wopapub/senate/senate/commttee/S10740_pdf.ashx

burden on family, friends, or caregivers (54.2%) and the loss of control of bodily functions, such as incontinence and vomiting (366.9%) .[25] **These are all disability issues.**

Any assisted suicide proposal that includes a subjective notion of suffering as part of the eligibility criteria would allow assisted suicide for a similar set of concerns.

This set of concerns reflects the day to day realities of life for many people living with disabilities of various kinds.

If we legalise assisted suicide for incontinence, a loss of ability to engage in one's favourite hobby, a need to have other's take care of your physical needs, a loss of mobility and so forth what is the take home message for those who live with these challenges every day?

The late Stella Young, comedian, writer and disability activist, wrote on the implications of legalising assisted suicide for people living with disabilities:

People make all sorts of assumptions about the quality of my life and my levels of independence. They're almost always wrong.

I've lost count of the number of times I've been told, "I just don't think I could live like you," or "I wouldn't have the courage in your situation," or, ***my favourite one to overhear (and I've overheard it more than once), "You'd just bloody top yourself, wouldn't you?****".*

Also, social attitudes towards disabled people come from a medical profession that takes a deficit view of disability. This is my major concern with legalising assisted death; that it will give doctors more control over our lives. As a disabled person who has had a lot to do with the medical profession, I can tell you that this is the space in which I've experienced some of the very worst disability prejudice and discrimination. Doctors might know about our biology, but it doesn't mean they know about our lives.

Media reports on assisted dying feed these misconceptions. ABC News reported this week on the case of Barbara Harling, a Queensland woman with motor neurone disease who said that she would consider moving to Tasmania if the Voluntary Assisted Dying Bill had passed. Harling is quoted as saying: "Well, let's put it this way. I can use my left hand, my right hand is just about useless. If I can't use my left hand to wipe my bottom, then I can do nothing else for myself. That means someone has to do everything for me. I couldn't bear to live like that."

The thing is, a lot of people do live like that. I know many, many people who depend on personal assistants for all of their daily living tasks, some of them requiring 24 hour care. ***Having to rely on someone else to wipe your bum may not be something anyone aspires to, but I'm quite sure it's never killed anyone.*** [26]

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[25] https://assets.nationbuilder.com/australiancarealliance/pages/96/attachments/original/1552018763/Oregon_-_Twenty_one_years_of_assisted_suicide.pdf?1552018763

[26] http://www.abc.net.au/rampup/articles/2013/10/18/3872088.htm

Proposals for assisted suicide offer require assessing doctors to screen for depression or other mental health conditions that may be affecting the person's decision making capacity. Similarly the assessing doctors are supposed to determine that the request is voluntary and not the result of coercion.

Doctors are less likely to identify depression in people with disability, simply by assuming that it is normal for a person with disability to show signs of depression such as sadness and lack of hope.

Doctors may also easily miss the particular vulnerability of a person living with disability to overt or subtle coercion from family or caregivers who reinforce a feeling that the person is a burden, "*too much trouble*", "*life is too hard*" and so forth.

Claire Freeman, who is tetraplegic after a car accident at age 17, reports that after four unsuccessful suicide attempts a suicide counsellor actually recommended she try assisted suicide at a facility in Switzerland.

She points out that the psychologist and a psychiatrist who saw her after a suicide attempt, were looking at her and just seeing the disability. "They were not saying, 'Hey, what's going on in your life? Are you working too much? Are you in too much pain?' "None of those questions were asked, it was just, 'Of course she wants to die, she's in a wheelchair, she's in pain.'"

Claire, now aged 40 years, has gone on to do a doctorate on decisions around mobility equipment, to be a model at Milan's Fashion Week. She is also currently contributing to a documentary opposing proposals to legalise euthanasia in New Zealand.[27]

Legalising assisted suicide poses a direct threat to the lives of some people with disabilities who may be assessed as eligible to request it. Doctors are more likely to agree that they are "*better off dead*" and to miss signs of depression or coercion.

Legalising assisted suicide for being a burden, incontinence and loss of ability to enjoy activities trivialises issues faced daily by persons living with disability and demeans their courage in facing the challenges of life.

Can we rule out coercion if we legalise assisted suicide?

Assisted suicide and euthanasia laws usually require that a request be voluntary and free of coercion. To be truly voluntary a request would need to be not just free of overt coercion but also **free from undue influence, subtle pressures and familial or societal expectations**.

A regime in which assisted suicide is made legal and in which the decision to ask for assisted suicide is positively affirmed as a wise choice in itself creates a framework in which a person with low self-esteem, or who is more susceptible to the influence of others, may well

[27] https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12211310

express a request for assisted suicide that the person would otherwise never have considered.

Elder abuse, including from adult children with "***inheritance impatience***" is a growing problem in Australia. This makes legalising assisting suicide unsafe for the elderly.

Undue influence is increasingly being seen as a relevant factor in the financial abuse of elders.

Seniors Rights Victoria provides a useful summary of case law and best practice on undue influence in the financial abuse of elders.[28]

It is clear from this summary that undue influence can easily be missed and may be difficult to identify. Of course, the courts can apply the remedy of recission if it is established. In the case of assisted suicide a failure to spot undue influence before writing a prescription for a lethal dose will be incapable of remedy once the lethal dose is ingested.

A recent parliamentary report on Elder Abuse in New South Wales also referenced the failure of professionals to identify undue influence and so unwittingly facilitate elder abuse.[29]

It cites the Council on the Ageing NSW as observing that the *NSW Interagency policy on preventing and responding to abuse of older people:*

> *does not address the more common cases where elder abuse is perpetrated by a family member or carer 'in an environment of isolation, dependence and undue influence*. (para 5.13 on p. 54)

The report also notes that:

> *Capacity Australia observed that financial abuse is often fueled by ignorance and family conflict, as well as 'inheritance impatience'. It further noted that undue influence by one family member over another is commonly facilitated by legal professionals because of their failure to detect when an older person is struggling to manage their financial affairs, that is, when they lack financial capacity*. (para 6.6 on p. 80)

As long ago as 1885 in what is still cited in Australian law as the leading case on undue influence, Sir James Hannen described some of the kinds of subtle coercion that a frail, elderly or ill person may be subjected to that could be hard for any outside person to detect.

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[28] https://assetsforcare.seniorsrights.org.au/relationship-breaks-down/equity/undue-influence-unconscionable-dealing/

[29] https://www.parliament.nsw.gov.au/committees/DBAssets/InquiryReport/ReportAcrobat/6063/Report%252044%2520-%2520Elder%2520abuse%2520in%2520New%2520South%2520Wales.pdf

The coercion may of course be of different kinds, it may be in the grossest form, such as actual confinement or violence, or a person in the last days or hours of life may have become so weak and feeble, that a very little pressure will be sufficient to bring about the desired result, and it may even be that ***the mere talking to him at that stage of illness and pressing something upon him may so fatigue the brain, that the sick person may be induced, for quietness' sake, to do anything.*** *This would equally be coercion, though not actual violence.*[30]

Evidence from jurisdictions that have legalised assisted suicide or euthanasia shows that coercion, including the feeling of **being a burden on others, is a real problem.**

The data from Oregon shows that in 2018 more one out of two (54.16%) people who died after taking prescribed lethal medication cited concerns about being a "*Burden on family, friends/caregivers*" as a reason for the request.[31]

In a further 14.9% of cases (nearly one in seven cases) the attending physician reported not knowing if the person who requested lethal medication and subsequently died after ingesting had a concern about physical or emotional burden on family, friends or caregivers.[32]

ORS 127.815 sets out as the very first responsibility of an attending physician under the Death With Dignity Act a duty to "*Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily*"

How can a physician come to a firm conclusion that a person is voluntarily requesting lethal medication in order to end their lives without exploring whether or not the person is motivated by a concern about the physical or emotional burden on family, friends or caregivers.

Surely such a discussion is necessary to exclude any possibility that the person is making the request under duress, subject to coercion or undue influence from a family member or caregiver.

Additionally, in the absence of such a discussion there may be a missed opportunity to relieve the person's concern about being a burden by arranging respite for family caregivers or additional care or support.

If the 14.9% of cases where the attending physician does not even bother exploring this issue with a person before writing a prescription for lethal medication are added to the 54.2%

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[30] https://swarb.co.uk/wingrove-v-wingrove-1885/

[31] Oregon Public Health Division, *Oregon Death With Dignity Act: 2018 Data Summary, Table 1,* p.12 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

[32] https://assets.nationbuilder.com/australiancarealliance/pages/96/attachments/original/1552018763/Oregon_-_Twenty_one_years_of_assisted_suicide.pdf?1552018763

of cases in 2018 where the attending physician reports knowing that the person had a concern about the physical or emotional burden on family, friends or caregivers then in nearly seven out of ten cases (69.1%) concern about being a burden is or maybe a factor in a request for lethal medication.

The data from Washington[33] shows that in 2017 more than half (56%) of those who died from prescribed lethal drugs cited concerns about being a "*Burden on family, friends/caregivers*" as a reason for the request.

Does the concern about being a burden originate from the person or is it generated by subtle or not so subtle messages from family, friends and caregivers - including physicians - who find the person to be a burden or a nuisance or just taking too long to die?

Some supporters of assisted suicide **don't care if some people are bullied into killing themselves** under an assisted suicide law.

Dr Henry Marsh, a British neurosurgeon and proponent of legalising assisted suicide and euthanasia, has acknowledged the possibility of coercion and elder abuse leading to wrongful deaths under such a law but he simply doesn't care:

"Even if a few grannies get bullied into [suicide], isn't that the price worth paying for all the people who could die with dignity?" [34]

It is clear from this evidence that simply requiring a physician to tick a box stating the person requesting assisted suicide is doing so voluntarily is no guarantee that the physician has the competence or has undertaken the extensive and careful inquiries necessary to establish that the person is not subject to undue influence or subtle pressure (albeit unwittingly) from family, friends or society to request assisted suicide so as not to burden others.

No jurisdiction that has legalised assisted suicide has even made any serious effort to establish a genuinely safe framework in this regard. Indeed no such framework is possible.

Any law permitting assisted suicide or euthanasia will inevitably result in wrongful deaths from coercion.

Social contagion of suicide

Legalising assisted suicide for some South Australians undermines the commitment to **suicide prevention for all** South Australians.

Proposals to legalise assisted suicide or euthanasia for a select group of people, such as the terminally or chronically ill, necessarily imply that society agrees such people may be better off dead and supports their suicide as a legitimate, rational choice to be facilitated rather than prevented.

[33] https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf
[34] https://www.medscape.com/viewarticle/879187

The question arises as to how publicly and openly offering assistance to commit suicide to one group of South Australians fits with the public policy goal, widely shared across the whole community, to reduce the incidence of suicide?

The overall suicide rate in South Australia has decreased by 11.11% from a high of 14.4 suicides per 100,000 people in 2014 to 12.8 per 100,000 people in 2017 but much more needs to be done.[35]

The *South Australian Suicide Prevention Plan 2017-2021* correctly identifies people living with chronic pain and illness especially terminal illness as living in a situation associated with a greater risk of suicide".[36] However, no specific measures to reduce the suicide rate for this vulnerable, at risk group are identified.[37] The Plan aims to engage the whole community in efforts to reduce the suicide rate in South Australia.

Courtesy of [Second Thoughts Connecticut]

[35] Australian Bureau of Statistics, *3303.0 - Causes of Death, Australia, 2017,* https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3

[36] *South Australian Suicide Prevention Plan 2017-2021*, p. 9https://www.sahealth.sa.gov.au/wps/wcm/connect/89cf2e8040a76656898cfb2559774525/South+Australian+Suicide+Prevention+Plan_June+2018_Final.pdf

[37] Ibid., p. 13

Legalising assisted suicide has been shown to lead to **an increase in the overall rate of suicides of 6.3%** and of the elderly (65 years and older) by 14.5%.

Proponents of assisted suicide have claimed that providing the elderly, terminally ill with a legal lethal dose of drugs to facilitate assisted suicide will reduce the incidence of other forms of suicide among this group and, because, it is claimed, many of those for whom the lethal dose is prescribed may never take it, actually decrease the overall suicide rate.

This hypothesis has been subjected to careful scrutiny in an important study by David Albert Jones and David Paton comparing trends in suicide rates in those states of the United States which have legalised assisted suicide compared to those which have not.[38]

The study, which controlled for various socio-economic factors, unobservable state- and year effects, and state-specific linear trends, found that legalizing assisted suicide was associated with a 6.3% increase in total suicides (i.e. including assisted suicides).

This effect was significantly larger in the over 65 year old age group with a massive 14.5% increase in total suicides.

The introduction of legalised assisted suicide was not associated with a reduction in non-assisted suicide rates, nor with an increase in the mean age of non-assisted suicide.

The conclusion is that assisted suicide either does not inhibit (nor acts as an alternative to) non-assisted suicide, or that it acts in this way in some individuals but is associated with an increased inclination to suicide in other individuals.

The latter suggestion would be consistent with the well known Werther effect of suicide contagion whereby suicide rates increase whenever **suicide is presented in a positive light** as a romantic or rational act.[39]

The real life impact of the Werther effect was most recently confirmed in a study demonstrating an increase in youth suicides following the screening of a television series called *13 Reasons Why*.[40]

Killed without request or while resisting

[38] https://pdfs.semanticscholar.org/6df3/55333ceecc41b361da6dc996d90a17b96e9c.pdf

[39] http://journals.sagepub.com/doi/abs/10.1080/00048670701266680

[40] Jeffrey A Bridge et al., "Association Between the Release of Netflix's *13 Reasons Why* and Suicide Rates in the United States: An Interrupted Times Series Analysis", Journal of the American Academy of Child & Adolescent Psychiatry, Article in press, Accepted manuscript available (as at 2 May 2019) at: https://issuu.com/thecolumbusdispatch/docs/association_between_the_release_of_

Those who are killed **without any request** by doctors who have grown used to the practice of ending their patients' lives are clearly wrongful deaths. In some cases a doctor has performed euthanasia even where a person resisted.

In the Netherlands in 2015 there were 431 cases of euthanasia without explicit request, representing 6.06% (or more than one out of sixteen) of all euthanasia deaths.[41]

More than 1 in 200 (0.52%) of all deaths (other than sudden and expected deaths) of 17-65 year olds in the Netherlands are caused intentionally by euthanasia without an explicit request from the person being killed.

In Case 2016-85 the Review Committees found that a doctor had not acted with due diligence in administering euthanasia to a woman with Alzheimer's disease. The woman had made a general reference in a living will to wanting euthanasia at the "right time". At the time the doctor euthanased her she was incompetent to voluntarily request it.

The doctor put medication in her coffee to reduce her consciousness deliberately so as to avoid her resisting being given drugs. Nonetheless she physically struggled against the administration of an intravenous lethal injection. **She was physically restrained by family members while the doctor completed the administration of the lethal drugs**.[42]

On 13 June 2018 the Regional Disciplinary Court for Healthcare in The Hague considered a complaint against the doctor brought by the Inspectorate for Health Care and Youth. The decision was published on 24 July 2018.[43]

The Court found that the written declaration of intent was not sufficiently clear to justify euthanasia in this case. It also found that the doctor should have tried to discuss the execution of euthanasia with the patient beforehand.

Despite its finding that the doctor had seriously breached the requirements for euthanasia it only imposed a reprimand on the doctor.

On 9 November 2018 it was announced that a criminal investigation into this case by the Board of Public Prosecutors had concluded and that the doctor would be prosecuted.[44]

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[41] https://opendata.cbs.nl/statline/#/CBS/en/dataset/81655ENG/table?ts=1525401083207

[42] https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2016/april/12/jaarverslag-2016/RTE_jaarverslag2016.pdf

[43] https://www.tuchtcollege-gezondheidszorg.nl/binaries/tuchtcolleges-gezondheidszorg/documenten/publicaties/documentatie-procedures/uitspraken/uitspraken-van-persberichten/beslissing-euthanasie-bij-dementie/2018-033bes.pdf

[44] https://www.om.nl/vaste-onderdelen/zoeken/@104443/nursing-home-doctor/

This is the first time that the Dutch Public Prosecution Service (OM) will prosecute a doctor for euthanasia since the introduction of the Act on Termination of Life on Request and Assisted Suicide in 2002.

> *After extensive investigation, the public prosecutor came to the conclusion that the nursing home doctor had not acted in accordance with the legal standards. The public prosecutor considers it important* **that the court assesses whether the doctor was entitled to rely on the living will completed by the woman**. *In addition, the OM reproaches the physician that she assumed that the woman still wanted to die without verifying this with the woman. Although the woman had regularly stated that she wanted to die, on other occasions she had said that she did not to want to die. In the opinion of the OM,* **the doctor should have checked with the woman whether she still had a death wish by discussing this with her**. *The fact that she had become demented does not alter this, because according to the Public Prosecution, the law also requires the doctor to verify the euthanasia request in such a situation.* **These two legal questions on the termination of life of people suffering from dementia justify the submission of this case to the criminal court judge**.

It is not yet known when the case will be heard by the District Court of The Hague.

INHUMANE DEATHS BY ASSISTED SUICIDE AND EUTHANASIA

The case for legalising assisted suicide and euthanasia **simplistically assumes** that once legalised such deaths will be both rapid and peaceful. However, this is not the case. As a recent article in the journal *Anaesthesia* found:

Complications related to assisted dying methods were found to include difficulty in swallowing the prescribed dose (≤9%), a relatively high incidence of vomiting (≤10%), prolongation of death (by as much as seven days in ≤4%), and failure to induce coma, where patients re-awoke and even sat up (≤1.3%).

This raises a concern that some deaths may be inhumane.

Deaths by assisted suicide or euthanasia that are inhumane are wrongful deaths. Unless such deaths can be ruled out then a scheme to legalise assisted suicide or euthanasia should be rejected. It simply doesn't meet the test of delivering what it claims: a rapid, peqaceful death.

Technical problems, complications and problems with completion in the administration of lethal drugs for euthanasia have been reported from the Netherlands.

Technical problems occurred in 5% of cases. The most common technical problems were difficulty finding a vein in which to inject the drug and difficulty administering an oral medication.

Complications occurred in 3% of cases of euthanasia, including spasm or myoclonus (muscular twitching), cyanosis (blue colouring of the skin), nausea or vomiting, tachycardia

(rapid heartbeat), excessive production of mucus, hiccups, perspiration, and extreme gasping. In one case the patient's eyes remained open, and in another case, the patient sat up.

In 10% of cases the person took longer than expected to die (median 3 hours) with one person taking up to 7 days.

From 2016 to July 2018 the Board of Procurators General reported on 11 cases of euthanasia with serious breach of protocols by the doctor, including a failed assisted suicide because the doctor ordered the wrong drug; **seven cases of the muscle relaxant being administered when the person was not in a full coma and therefore potentially causing pain**; and three cases where a first attempt at euthanasia failed and the doctor had to leave the person to get a second batch of lethal drugs.

In Oregon in 2018 one in nine (11.11%) of those for whom information about the circumstances of their deaths is available either had difficulty ingesting or regurgitated the lethal dose or had other complications. We simply do not know about the other eight out of nine cases.

Two people in Oregon had seizures in 2017 after ingesting the lethal poison.

The interval from ingestion of lethal drugs to unconsciousness has been as long as four hours (in 2017).

The time from ingestion to death has been as long as 104 hours (4 days and 8 hours). One person in 2018 took 14 hours to die.

A total of 8 people have regained consciousness after taking the supposedly lethal dose, including one person in 2018.

Two of the cases of regaining consciousness occurred after using DDMP2 – the latest experimental lethal cocktail being used by pro-assisted suicide doctors.

In Washington State in 2017 one person took 6 hours to lose consciousness after ingesting the lethal dose and one person took 35 hours to die after ingesting the lethal dose. In 2016 one person took 11 hours to lose consciousness after ingesting the lethal dose. In 2015 one person took 72 hours (3 days) to die after ingesting the dose. In 2013 one person took 3 hours to lose consciousness after ingesting the lethal dose and one person took 41 hours (1 day and 17 hours) to die after ingesting the dose. In 2009 two people awakened after initially losing consciousness. In 2014 one person suffered seizures after ingesting the lethal medication.

At least 18 patients have regurgitated the lethal medication. Seven of these cases occurred in 2016 alone.

This may be related to the use of new experimental cocktails of lethal drugs being used since the price of the previously used drugs, secobarbital and pentobarbital (Nembutal), escalated.

The first of the new cocktails is a mix of phenobarbital, chloral hydrate and morphine sulfate. It was prescribed in 88 cases in 2015 and 106 cases in 2016 but no longer prescribed in 2017 no doubt due to the fact that it was found to be very caustic and to cause a profound burning in the throat.

The second experimental cocktail includes morphine sulfate, propranolol, diazepam, digoxin and a buffer suspension (DDMP2). It was used in 4 cases in 2015, 53 cases in 2016 and 130 cases (66%) in 2017.

This latest attempt at an experimental lethal cocktail aimed at delivering a rapid and peaceful death is a failure.

The 2018 Data Summary from Oregon reports on 43 cases of (attempted or completed) assisted suicide using DDMP2 where the results were observed and recorded.

12 people out of 43 (27.9%) died between 13 and 59 minutes of ingesting the lethal cocktail.

19 people (44.18%) died between 1 and 6 hours of ingesting the lethal cocktail.

10 people (23.2%) **or almost one out of four people took between 6 and 21 hours to die** after ingesting the lethal cocktail.

2 people (4.65%) regained consciousness and did not die after ingesting the (supposedly) lethal cocktail.

Assisted suicide and euthanasia simply cannot guarantee a rapid and peaceful death.

VICTORIA

Assisted suicide and euthanasia are scheduled to become legal in Victoria on 19 June 2019 when the Voluntary Assisted Dying Act 2017,[45] which passed the Legislative Council on 22 November 2017 by just two votes (22-18).[46]

Regulations were gazetted in September 2018.[47]

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45 http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B320E209775D253CCA2581ED00114C60/$FILE/17-061aa%20authorised.pdf

46 https://www.parliament.vic.gov.au/images/stories/daily-hansard/Council_2017/Council_Daily_Extract_Tuesday_21_November_2017_from_Book_20.pdf

47 http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/93eb987ebadd283dca256e92000e4069/D550921996E9F89BCA258313001B4FE5/%24FILE/18-142sra%20authorised.pdf

Eligibility criteria

The core eligibility criterion is set out in Section 9 (1) (d) of the Act:

> *the person must be diagnosed with a disease, illness or medical condition that—*
>
> *(i) is incurable; and*
>
> *(ii) is advanced, progressive and will cause death; and*
>
> *(iii) is expected to cause death within weeks or months, not exceeding 6 months; and*
>
> *(iv) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable.*

The first three elements of this criterion are to be assessed by two doctors, one of whom is required to "*relevant expertise and experience in the person's disease, illness or medical condition*", the nature of such expertise and experience to be stated on Form 1 or Form 2 as set out in Schedule 1 of the Act.

None of the terms used in this provision are further defined in the Act nor any guidance given in the Regulations as to how they are to be assessed.

During debate on the Bill it became clear that there are uncertainties around the meaning of "i*ncurable*" and "*will cause death*" so that, for instance an insulin dependent diabetic who declines to take insulin may qualify under this criterion.

It was also accepted that there are misdiagnoses[48] and errors in prognosis[49] so that there will inevitability be some wrongful deaths.

It is important to note that the fourth element in the criterion relating to "suffering" is specifically NOT to be assessed by the two doctors. It is entirely subjective and therefore entirely meaningless. A person is suffering in the required sense simply if the person asserts that this is the case.

This approach applies in Canada but notably not in the Netherlands or Belgium where the objective nature of the suffering – and the incapacity to relieve it – is a matter for professional assessment by the physician, including a relevant specialist.

There is no definition of suffering and therefore nothing to exclude forms of existential suffering such as loss of autonomy, lack of capacity to enjoy former hobbies, feeling a burden on family or financial concerns to be the only suffering experienced. There is

[48] https://www.australiancarealliance.org.au/a_wrong_diagnosis

[49] https://www.australiancarealliance.org.au/a_wrong_prognosis_part_1

absolutely no requirement for the person to be experiencing pain or other physical symptoms.[50]

The mandated training module for Victorian doctors willing to participate in providing assessments for assisted suicide and euthanasia actually suggests that if a patient indicates that "*becoming a burden on family, friends and caregivers*" is their reason for seeking assisted dying this could be the "*patient's expression of suffering experienced from the loss of autonomy*".

Mental illness

Section 9 (2) of the Act provides that:

> *A person is not eligible for access to voluntary assisted dying only because the person is diagnosed with a mental illness, within the meaning of the* ***Mental Health Act 2014****.*

The force of the word "only" is the key to understanding the limited usefulness of this provision in protecting persons with mental illness.

It does not preclude a person with a profound mental illness but who also has another "*a disease, illness or medical condition"* that meets the criterion set out in section 9 (1) (d) of the Act from accessing assisted suicide or euthanasia.

Nor does it explicitly preclude a mental illness from itself being considered to be "*a disease, illness or medical condition"* that meets the criterion set out in section 9 (1) (d) of the Act. For example, a person with anorexia who is expected to die within 6 months as a result of refusing treatment could qualify or even a person with treatment resistant suicidal ideation. It remains to be seen whether the Act will be applied in this way.

Sections 18 (1) and 27 (1) provide respectively that if the co-ordinating medical practitioner or the consulting medical practitioner:

is unable to determine whether the person has decision-making capacity in relation to voluntary assisted dying as required by the eligibility criteria, for example, due to a past or current mental illness of the person, [he or she] must refer the person to a registered health practitioner who has appropriate skills and training, such as a psychiatrist in the case of mental illness.

It is entirely up to the assessing doctors to form their own view as to their expertise in assessing decision-making capacity. This provision is weaker than the corresponding

[50] https://www.australiancarealliance.org.au/access_to_palliative_care

provision in Oregon which refers to "*impaired judgement*"[51] rather than a lack of "*decision-making capacity*" which is defined in section 4 in purely cognitive terms, taking no account of the effects, say, of depression or demoralisation on a person judging what is truly in his or her best interests.

Under section 36 of the Act the two people witnessing the signature on the written declaration must certify in writing "*that, at the time the person signed the declaration, the person appeared to have decision-making capacity in relation to voluntary assisted dying*". This hardly adds any extra assurance to the process as the witnesses do not need to have any expertise or prior knowledge of the person.

There is a provision in section 68 of the Act for a person who is considered by VCAT (Victorian Civil and administrative Tribunal) to have "*a special interest in the medical treatment and care of the person*" assessed as eligible for assisted suicide or euthanasia to apply to VCAT for a review of the decision that the person has decision-making capacity.

Disability

Section 9 (3) of the Act provides that "A person is not eligible for access to voluntary assisted dying only because the person has a disability, within the meaning of section 3(1) of the **Disability Act 2006**."

Once again the key word is "*only*".

Nothing precludes a person with a disability – physical or intellectual – from accessing assisted suicide or euthanasia provided the person meets the other eligibility criteria.

Nothing precludes the person's disability from being considered as "*a disease, illness or medical condition*" expected to cause death within 6 months.

There are no explicit provisions to protect people with disability from discriminatory assessment under the required processes by doctors who would consider a person with a particular disability as "better off dead".

People with disability are more likely to experience undiagnosed depression especially following initial acquisition of a disability or adverse developments in their physical, psychological or social condition.[52]

The Act explicitly provides for requests for assisted suicide or euthanasia to be made by gestures. It is not made explicit in the Act whether or not an accredited interpreter is required in this case. A recent court case in the Netherlands determined that "*hand*

[51] https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/statute.pdf

[52] https://www.australiancarealliance.org.au/better_off_dead

squeezes, nods, eye blinking and crying were all sufficient signs of" a request for euthanasia.[53]

Coercion

The Act requires the two assessing doctors, as well as the witness to an administration request in the case of euthanasia, to certify that the person requesting assisted suicide or euthanasia is "*acting voluntarily and without coercion*".

Assessing doctors are required to complete training approved by the Secretary of the Department of Health on "*identifying and assessing risk factors for abuse or coercion*".

This training is part of an online module and is relatively brief and basic. Merely completing this online training cannot guarantee that assessing doctors never miss the signs of coercion or abuse given the well-documented evidence of failure by professionals in Australia to identify elder abuse as cited above.

There is no provision for anyone to seek a review at VCAT of an assessment by the two doctors that a person is acting "*voluntarily and without coercion*" in requesting assisted suicide or euthanasia. A family member or friend who becomes aware that a person is being coerced has no formal recourse under the Act at all.

State issued permits

Form 3 in the Regulations sets out what a VADSAP or "voluntary assisted dying self-administration permit" will look like.[54]

"*This self-administration permit in respect of Mary Brown authorises Dr John Smith for the purpose of causing Mary Brown death, to prescribe and supply the substance specified in this permit to Mary Brown that is able to be self-administered; and is of a sufficient dose to cause death*".

The permit will be signed by the Secretary of the Department of Health and Human Services or his or her delegate.

The permit will also directly authorise Mary Brown to "*use and self-administer the substance*" specified in the permit in order to cause her death.

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[53] https://www.australiancarealliance.org.au/euthanasia_consent_by_gestures

[54] http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/93eb987ebadd283dca256e92000e4069/D550921996E9F89BCA258313001B4FE5/%24FILE/18-142sra%20authorised.pdf

This is clearly not just State sanctioned suicide but – in a world first since ancient times – **State authorised suicide of a particular, named person using a specified lethal substance**.

Form 4 in the Regulations sets out what a VADPAP or "voluntary assisted dying practitioner administration permit" will look like.

"*This practitioner administration permit is issued to Dr John Smith … this practitioner administration permit in respect of Jim Brown for the purpose of causing Jim Brown death, authorises Dr John Smith to administer the substance to Jim Brown*."

This is **State authorised euthanasia of a named individual by a named doctor using a specified lethal substance**. It was last done in Germany in the 1940s.

The Regulations specify that the Secretary of the Department of Health and Human Services or his or her delegate will have 3 business days from receiving a VADSAP or VADPAP application form (accompanied by five other forms) to either issue the permit or refuse to do so.

All that the Secretary or his or her delegate will do is to check that two doctors have ticked the right boxes and filled in the blanks on the six forms.

None of this checking of ticked boxes can possibly guarantee that the person who the Secretary or delegate will authorise to commit suicide or to be killed by euthanasia really:

- has the alleged condition;[55]
- actually has only six months to live;[56]
- is not being coerced overtly or subtly by impatient heirs or weary caregivers;[57]
- is not depressed; [58]
- is not missing out on effective treatment; [59]
- is not being discriminated against due to disability;[60] and
- could not have had their suffering relieved with appropriate palliative care[61].

[55] https://www.australiancarealliance.org.au/a_wrong_diagnosis

[56] https://www.australiancarealliance.org.au/a_wrong_prognosis_part_2

[57] https://www.australiancarealliance.org.au/bullying_or_coercion

[58] https://www.australiancarealliance.org.au/mentally_ill_at_risk

[59] https://www.australiancarealliance.org.au/unaware_of_available_treatment

[60] https://www.australiancarealliance.org.au/better_off_dead

[61] https://www.australiancarealliance.org.au/access_to_palliative_care

Assisted suicide

The processes for assisted suicide are deeply flawed.

The "*poison or controlled substance or a drug of dependence specified in a voluntary assisted dying permit for the purpose of causing a person's death*" approved by the Secretary, prescribed by the doctor and issued by a pharmacist to the person will most likely be an experimental lethal cocktail of several substances prescribed "off-label" and to be mixed together before consumption.

On 5 January 2019 the Minister for Health, Martin Foley, announced that The Alfred Hospital pharmacy would be "the sole service for dispensing" the lethal cocktail across Victoria. "*For people too sick to travel, the pharmacy service will deliver them their medication and provide information on administration*".[62]

The notion of a kind of "uber-poison" service to country Victoria - where there is a chronic shortage in ready access to palliative care medicines as needed - is particularly disturbing.

There is no requirement for any doctor or other health practitioner to be present when the poison is ingested.

In Oregon, under a similar scheme, in 2017 for two out of three (66.43%) people there was no physician or other healthcare provider known to be present at the time of ingestion. More than one in nine (11.63%) of those for whom information about the circumstances of their deaths is available either had difficulty ingesting or regurgitated the lethal dose, had seizures or other complications or regained consciousness and died subsequently from the underlying illness.[63]

The interval from ingestion of lethal drugs to unconsciousness was as long as four hours while the time from ingestion to death was as long as 21 hours.

Imagine these complications occurring for a person who is home alone when they ingest the poison.

The Act does not require any assessment of decision-making competence or absence of coercion at the time of ingestion nor does it set any time limit on the length of time between the poison being prescribed under a VADSAP and it being ingested. In Oregon the longest duration between initial request and ingestion recorded is 1009 days (that is 2 years and 9 months).

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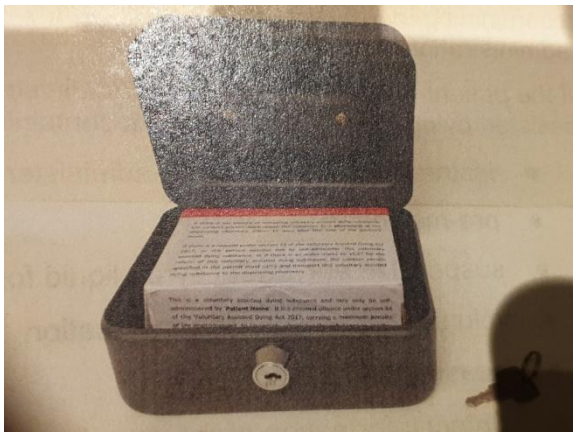
[62] https://www.premier.vic.gov.au/voluntary-assisted-dying-a-step-closer/
[63] https://www.australiancarealliance.org.au/happy_21st_oregon



The Regulations provide the specifications for the locked box in which the Act requires the lethal poison issued under a VADSAP to be stored. It must be made of steel. It must be "*not easily penetrable*". It must be "*lockable with a lock of sturdy construction*".

There are no requirements for where either the box containing the lethal poison or the key to open it are to be kept. However, section 126 of the Act does specifically exclude it from the usual protective requirements for dangerous medication in aged care services - so it may have t**o be kept under grannie's bed in her aged care room**.

And of course if there is no witness we will never know if the person really self-administered the poison or if it was administered to them by a family member or other person under duress, surreptitiously or violently.

Euthanasia

Section 48 of the Act allows for euthanasia (practitioner administration of the poison) as an alternative to assisted suicide in the case where a single doctor certifies that he or she is satisfied that "*the person is physically incapable of the self-administration or digestion of an appropriate poison or controlled substance or drug of dependence*" and provides a reason for this incapacity in completing Form 8 of schedule 1 of the Act and Form 2 as set out in the Regulations .

It remains to be seen what criteria, if any, will be used by the Secretary in approving VADPAP requests. It is quite likely that any assertion of such physical incapacity by a doctor will be accepted at face value.

If so, given the overwhelming preference for euthanasia over assisted suicide in the two jurisdictions where both means of causing death are available, euthanasia could, over time, become the more prevalent method in Victoria.

Comparative statistics between jurisdictions permitting only assisted suicide and those permitting both assisted suicide and euthanasia suggest that where euthanasia is available the overall rate of deaths from assisted suicide and euthanasia is significantly higher.

How this plays out in Victoria remains to be seen.

Conclusion

On 19 June 2019 Victoria will embark on the fifteenth in a series of experiments in legalised euthanasia or assisted suicide begun in the Northern Territory in 1996. Each of these experiments has proved to be fatally flawed resulting in wrongful deaths. There is nothing in the design of the Victorian experiment to justify any expectation of better results.

CONCLUSION

Any proposal to change the law on murder and counselling and aiding suicide to exempt doctors who prescribe and/or administer lethal poison to a specified category of persons requires the most careful scrutiny.

Can any such scheme avoid wrongful deaths?

Can any such scheme guarantee a humane, rapid and peaceful death?

The evidence cited above, drawn principally from official reports from jurisdictions such as the Netherlands, Belgium, Oregon and Washington State shows conclusively that no such scheme has yet been found.

For a full analysis of all sixteen jurisdictions where assisted suicide and/or euthanasia have been legalised see our publication *Sixteen Fatally Flawed Experiments*.[64]

For further information on wrongful deaths see our publication *Eleven Categories of Wrongful Death*.[65]

Based on this evidence we urge the Committee to recommend that there be no change to the law in South Australia that would permit either assisted suicide or euthanasia.

[64] https://www.australiancarealliance.org.au/flawed_experiments

[65] https://www.australiancarealliance.org.au/wrongful_categories