Submission to the Health and Environment Committee, Parliament of Queensland on the

Voluntary Assisted Dying Bill 2021

From the Australian Care Alliance, prepared by Richard Egan

EXECUTIVE SUMMARY

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

The *Voluntary Assisted Dying Bill 2021* is such a Bill. Indeed, s147 (2) makes it clear beyond doubt that the Bill **provides exceptions to the law on murder and assisted suicide**.

The necessity of such a provision makes it clear that the acts of **prescribing a lethal poison with the intention that a person ingest it to end the person's life** and of **injecting a lethal poison in order to cause the death of the person** that would be authorised by the Bill, are acts that in all other cases are treated as criminal offences.

How will the scheme established by the Bill **avoid wrongful deaths**? How will such a scheme **guarantee a humane, rapid and peaceful death**?

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

An analysis of the provisions of this Bill shows that it is subject to the same **fatal flaws** as the laws in these jurisdictions and **will not prevent wrongful deaths.**

For a full analysis of all eighteen jurisdictions where assisted suicide and/or euthanasia have been legalised see our publication *Fatally Flawed Experiments*.[1]

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

There are twelve categories of wrongful death that this Bill would fail to prevent:

1. A wrong diagnosis – doctors make mistakes, so the person may not even have a terminal illness; as the deaths will not be reportable to the coroner and there will be no autopsies we will never know about these cases (Example: Pietro D'Amico, Switzerland 2013, found after an autopsy not to have had a terminal illness despite diagnosis by both Italian and Swiss doctors)
2. A wrong prognosis – many people have outlived a 12 month prognosis by months, years or even decades (Example: Jeanette Hall, Oregon, all set for assisted suicide in Oregon in 2000 based on prognosis of terminal cancer with less than "six months to live" – another doctor persuaded her to try treatment and she is still alive today.)
3. Unaware of or unable to access effective treatment – doctors many not know of new, effective treatments (Example: Case 15 of the 2011 Regional Euthanasia Review Committees involved a woman who was not given the proper treatment for back pain.)
4. No access to palliative care – palliative care is underfunded and unevenly available in Queensland; also many doctors are inadequately trained in palliative care; people may die whose suffering – whether physical, psychological or existential - could have been relieved to their satisfaction with gold standard palliative care
5. Denied funding for medical treatment – no one should have their life ended because they can't afford treatmnet. (Example: Roger Foley, a 45 year-old man with a neurodegenerative disease when seeking home care was repeatedly told by Canadian hospital staff that he could access euthanasia instead.)
6. Mentally ill at risk of wrongful death – depression associated with a terminal diagnosis can be treated but is often missed by doctors. (Example: Belgium is now openly euthanasing young people with mental illness caused by domestic violence, psychological neglect and sexual abuse – 25 people under 40 years of age between 2014 and 2017 alone. Canada is scheduled to start euthanasing the mentally ill in March 2023.)
7. Better off dead than disabled – many people with disabilites have been told by a doctor that they would be better off dead. The Bill validates that disccriminatory attitude. (Example: Belgium and the Netherlands allow euthanasia for intellectual disabilities such as Asperger's and physical disabilities such as blindness.)
8. Can we rule out coercion if we legalise assisted suicide? - doctors miss the signs of elder abuse and coercion. The Bill will not prevent an elderly person being bullied or subtly persuaded to ask for their life to be ended – for someone else's convenience or gain. (Examples: Jennifer Morant was persuaded to commit suicide by her husband Graham, who was subsequently convicted under Queensland law prohibiting such acts. Laws permitting euthanasia or assisted suicide necessarily facilitate such acts – instead of persuading a burdensome relative to hang or gas themselves you just persistently remind them that euthanasia is now "their legal right". Nurse Claire-Marie Le Huu-Etchecopar reports repeatedly witnessing such coercion in Belgium between 2008 and 2014.)
9. Social contagion of suicide – overall suicide rates have gone up where these laws are in place. (Example: By 2020 suicides in Victoria had increased by 21.2% since assisted sucide was legalised in 2017 – based on a claim it would prevent 50 suicides per year - instead there were 148 additional suicides in 2020).

10. Killed without request or while resisting – evidence shows that some doctors get used to ending people's lives "on request" and go on to end the lives of other patients without a request. (Example: In the Netherlands in 2015 there were 431 cases of euthanasia without an explicit request, representing 6.06% of all cases of euthanasia that year.)
11. Lacking decision-making capacity – a terminal diagnosis can affect decision-making capacity in a way missed by many doctors. (Under the Bill there is no check of decision-making capacity when self-administration occurs – which may be months after it was prescribed. If the person was tricked or bullied into ingesting it, who would know?)
12. Inhumane, lengthy deaths – all substances used to cause death have a significnat complication rate and do not guarantee a peaceful, rapid, painles death. Some people will experience seizures, a prolonged time to loss of consciousness and/or to death. Some deaths will be painful. (*Anaesthesia* 2019: (*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.*)

Note: More detail and full references for examples are given in the body of the submission below.

For further information on wrongful deaths see our publication *Twelve Categories of Wrongful Death*.[2]

It is the considered position of the Australian Care Alliance, based on a review of all the available evidence, that none of the jurisdictions that have legalised euthanasia and/or assisted suicide have succeeded in establishing a genuinely safe framework for assisted suicide and euthanasia and that this Bill likewise fails to do so.

Based on this evidence we urge the Committee to recommend that the Bill not be passed.

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

Contents

INTRODUCTION

The Australian Care Alliance was initially 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 now works nationally throughout Australia.

This submission notes that the Committee is seeking submission on aspects of the Bill and not on the broader policy debate. This submission is accordingly directed at examining whether the Bill would create a legal regime that would guarantee that there would be no wrongful deaths and that every death it authorised would be peaceful, rapid and humane.

Terminology

The Bill (Schedule 1: Dictionary) would provide that "***voluntary assisted dying*** means the administration of a ***voluntary assisted dying substance***."

Section 160 of the Bill defines a "***voluntary assisted dying substance***" to be "a S4 substance or S8 substance, or a combination of those substances" approved by the chief executive "for use under this Act for the purpose of causing a person's death."

This makes it clear that "voluntary assisted dying" does not refer to any processes that simply make the dying process more comfortable but to acts directed at the administration of a poison in sufficient doses to cause death.

Section 50 of the Bill specifies that the lethal poison may either be ***self-administered*** – that is the person may be prescribed a lethal poison by a practitioner to be ingested by that person in order to cause the person's death – or ***practitioner administered*** – that is the lethal poison may be injected by the practitioner or nurse in order to cause the person's death.

This submission will, in order not to collaborate with the use of euphemistic terms used to make harsh realities seem more palatable, use the term ***assistance to suicide*** for the act of prescribing a lethal poison to be used for self-administration (suicide) and ***euthanasia*** for the act of administering a lethal poison to a person to cause the person's death.

In this context we are using euthanasia, if not otherwise qualified, to refer to active euthanasia which is at least "voluntary" in form if not in substance.

Criminal Code s302: the offender intends to cause the death of the person killed

The key element of the crime of murder, as defined in s302 of the *Criminal Code*, is that "*the offender intends to cause the death of the person killed*". This is also the key element of an act of euthanasia. Section 296 of the *Criminal Code* on "**Acceleration of death**" provides that even where a person is "l*abouring under some disorder or disease arising from another cause*" doing an act which "*hastens the death*" of the person is still deemed to have killed that person.

Section 311 of the *Criminal Code* provides that:

> *Any person who … counsels another to kill himself or herself and thereby induces the other person to do so; or aids another in killing himself or herself; is guilty of a crime, and is liable to imprisonment for life.*

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 become lawful to counsel and to aid suicide.

The Bill would make these changes to the operation of the Queensland Criminal Code.

Accordingly, as it would create exceptions to the laws prohibiting both murder and counselling or aiding a person to kill himself or herself, the Bill should be subject to the most careful scrutiny.

THE PROPER TEST FOR SAFELY PROVIDING NEW EXCEPTIONS TO THE LAW ON MURDER AND AIDING SUICIDE

What should the test be for establishing that this change to the law on murder and on counselling and aiding suicide at the heart of the Bill can be done safely?

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

Andrew Denton, Go Gentle Founder and Director told The Project[3]:

> *There is no guarantee ever that doctors are going to be 100% right.*

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*?"[4]

This is precisely the question that the Committee needs to ask.

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

> "*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*?"

[3] https://youtu.be/VvsN47Uqbt0
[4] https://www.medscape.com/viewarticle/879187 [Free registration required to view article]

In considering a legal regime in which capital punishment is permitted, it would never be thought that simple compliance with the external forms is sufficient to answer the question as to whether deaths may be wrongfully brought about or painfully executed.

It is not enough to assert that the police charged a person under a valid law and using the proper processes; that a properly selected and instructed jury returned a verdict of guilty; that a judge properly considered sentencing principles; and that the death is executed according to the approved protocol. Tick, tick, tick all the boxes.

The real argument is over whether external compliance with these processes is sufficient to **guarantee** that no innocent person, or no person for whom mitigating circumstances such as intellectual disability or mental illness ought to have precluded a death sentence, is wrongly sentenced to death and executed; and that the execution of the death sentence is in **reality** painless, rapid and humane.

The Bill is built on the assumption that simply because two doctors have ticked a box that a person has a terminal illness, will die within twelve months, has decision making capacity, is not being coerced and so forth that this equates to reality. There is an entirely unwarranted assumption of infallibility on the part of doctors that we are not willing to concede to the police, to juries or to learned judges.

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

Our analysis of the Bill confirms that there is no new feature to the regime it would establish that, unlike all other such regimes, would exclude either wrongful or inhumane deaths.

WRONGFUL DEATHS: TWELVE CATEGORIES

This submission identifies twelve categories of wrongful deaths that have or can occur under any scheme so far in place or proposed which legalises assisted suicide and/or euthanasia and that will, without doubt, occur in Queensland if this Bill were to be enacted.

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. lack of decision-making capacity
12. inhumane deaths by assisted suicide or euthanasia that are neither rapid nor peaceful

The challenge for the Committee then is to transparently examine the evidence and to consider whether the Bill, unlike any other scheme yet enacted or proposed, would ensure that in assessing applicants to be prescribed or administered lethal poisons and in the administration of those lethal poisons:

1) Doctors never make errors in diagnosis
2) Doctors never underestimate a prognosis
3) Doctors are aware of all available effective treatments and that all persons in Queensland, including in remote and indigenous communities, have equitable access to those treatments
4) World’s best practice palliative care is available to every Queenslander, including in remote and indigenous communities
5) No Queenslander considers assisted suicide or euthanasia because of financial concerns about the cost of treatment or care, including the full range of palliative care
6) Doctors never miss diagnosing clinical depression or demoralisation in persons with a terminal or chronic illness
7) Doctors never project a discriminatory attitude towards persons with disabilities being more readily inclined to the view that a person with disabilities would be acting rationally in choosing to end their life
8) Doctors never fail to identify elder abuse, coercion or undue influence by family members or others including any influence on a person’s decision to request assisted suicide or euthanasia based on subtle societal expectations
9) There will be no suicide contagion
10) No doctors will become used to ending the lives of their patients and, regardless of the letter of the law, take actions to intentionally end the lives of other patients who do not make an explicit request
11) Doctors never fail to properly assess the decision-making capacity of a person requesting euthanasia or assistance to suicide.
12) Every death from the self-administration or doctor-administration of a lethal poison under the scheme established by the Bill will be guaranteed to be both rapid and

peaceful and that there will be no complications such as seizures, regurgitation, lengthy periods between ingestion/administration and loss of consciousness or between ingestion/administration and death

The Committee should acknowledge that these guarantees would not be achieved by the Bill and accordingly recommend that it not be passed.

TWELVE CATEGORIES OF WRONGFUL DEATH

The Australian Care Alliance has identified twelve categories of wrongful death that will inevitably result from the scheme legalising assistance to suicide and euthanasia that would be established by the Bill.

A wrong diagnosis

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

There are only two ways to ensure that there are no such wrongful deaths from euthanasia or assistance to suicide:

- ensure that physicians never make mistakes in diagnoses. Unfortunately, this is not achievable; or
- retain the laws prohibiting euthanasia and assistance to suicide by not passing the Bill.

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*." [5]

Ten per cent of cases in Australia are misdiagnosed according to Peter McClennan, chief executive at Best Doctors.[6]

A September 2020 article reported that "*In Australia, an estimated 140 000 cases of diagnostic error occur each year*" and that *"'overconfidence in incorrect diagnoses' was a key factor".* Furthermore,

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

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

"*Between 11% and 40% of listed diagnoses in older patients with Parkinson disease, dementia, heart failure and chronic obstructive pulmonary disease do not satisfy accepted diagnostic criteria*".[7]

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, illustrates that such mistakes do happen.[8] If assistance to suicide or euthanasia 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.[9]

Simply having two doctors diagnose that a person has a terminal illness is an illusory safeguard. This is made even more likely under the Bill than in some other jurisdictions as there is no requirement for either assessing practitioner to be a specialist or to have any experience in the relevant field for the alleged terminal illness.

We note that, although amending the Bill to include such a requirement may lessen the rate of misdiagnosis it cannot eliminate it altogether.

Section 21 (1) (a) of the Bill requires a referral to "a registered health practitioner with the appropriate skills" to determine whether the person has "the person has a disease, illness or medical condition that meets the requirements of section 10(1)(a)" but only where the assessing practitioner considers that he or she is unable to make this determination. There is no guarantee that all assessing practitioners will be aware of their lack of competence in making such a determination and make the required referral.

There is no remedy for a wrongful death by euthanasia or assistance suicide based on misdiagnosis.

Additionally, **the requirement to lie in completing** the death certificate of a person who has died due to the self-administration or practitioner administered lethal poison which is

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[7] Ian Scott and Carmel Crock, "Diagnostic error: incidence, impacts, causes and preventive strategies", *Medical Journal of Australia*, 2020; 213 (7): 302-305.e2, Published online: 21 September 2020, https://onlinelibrary.wiley.com/doi/abs/10.5694/mja2.50771

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

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

imposed on doctors by s83 (3) (a) of the Bill, and the exclusion by s171 of the Bill of such deaths from being reportable to the Coroner, make it almost impossible for such misdiagnoses to ever come to light.

Any claim in the future that there are no wrongful deaths by misdiagnosis under the Queensland Bill will therefore be specious as there is not only no mechanism under the Bill for identifying these deaths but the Bill actively provides for such deaths to be hidden from scrutiny.

How many wrongful deaths from euthanasia or assistance to 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 twelve 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 twelve months under this Bill 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*".[10]

Another paper describes doctors' ability at predicting survival at 1 year as "*only slightly better than a random guess*".[11]

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.[12]

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**.

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

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

[12] 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 for assistance to 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.[13]

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).[14] 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.*

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

[14] 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

Five years later she saw me in a restaurant and said, "Dr. Stevens, you saved my life!"

For her, the mere presence of legal assisted suicide had steered her to suicide.[15]

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.

Section 21 (1) (a) of the Bill requires a referral to "a registered health practitioner with the appropriate skills" to determine whether the person has "the person has a disease, illness or medical condition that meets the requirements of section 10(1)(a)", including whether the condition is "expected to cause death within 12 months", but only where the assessing practitioner considers that he or she is unable to make this determination. There is no guarantee that all assessing practitioners will be aware of their lack of competence in making such a determination and make the required referral.

How many wrongful deaths by euthanasia or assistance to suicide under the Bill where the deceased was wrongly given a prognosis of less than 12 months to live, but may have lived for years, would be 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 assistance to suicide or euthanasia.

The Bill does not have any requirement for either assessing practitioner to have any specialist qualifications or relevant experience and so the likelihood of an applicant not being advised of an effective treatment is increased even more.

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.

[15] 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

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.*[16]

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.**[17]

No legal framework permitting assistance to 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.

The requirements the Bill imposes on a practitioner when proposing euthanasia or assistance to suicide (***section 7(2)(a)***) to a person and before accepting a request for euthanasia or assistance to suicide (***section 22(b)***) to inform the person of "the treatment options available to the person and the likely outcomes of that treatment" are only as effective as the practitioners' knowledge and expertise. The Bill does not require them to have any such knowledge or expertise.

How many wrongful deaths by assistance to suicide or euthanasia under the Bill where the person missed out on effective treatment would be too many?

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 did 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*

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

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

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*."[18]

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.

[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.[19]

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 Queenslander deserves access to

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

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

gold standard palliative care which can alleviate pain, including using palliative sedation as a last resort.

The requirements the Bill would impose on a practitioner when proposing euthanasia or assistance to suicide (***section 7(2)(b)***) to a person and before accepting a request for euthanasia or assistance to suicide (***section 22(c)***) to inform the person about "the palliative care and treatment options available to the person and the likely outcomes of that care and treatment" are only as effective as the practitioners' knowledge and expertise. The Bill does not require them to have any such knowledge or expertise.

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.

How many such wrongful deaths under the Bill would be too many?

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[20]and Randy Stroup,[21] 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."

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.[22]

[20] https://abcnews.go.com/Health/story?id=5517492

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

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

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.[23]

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 assessing practitioner 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?

Not every Queenslander, especially those in remote areas or indigenous communities, has equal access to affordable medical care.

The Bill would permit euthanasia or assistance suicide with no guarantee that not a single Queenslander will have their lives ended wrongfully by these means because affordable, life-saving treatment was not offered to them.

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.

Section 13 of the Bill, while excluding euthanasia or assistance to suicide **only** because a person has a mental illness, also affirms that applicants with a mental illness may be given access to euthanasia or assistance to suicide if the person is held to be eligible under section 10 of the Bill.

Indeed, this would allow an assessing practitioner to conclude, under Section 10, that a person is eligible for euthanasia or assistance to suicide because the person has a treatment-resistant mental illness, with a record of suicidal ideation and suicide attempts, which is expected to cause the person's death within 12 months.

In Belgium in 2020, three out of 21 (14.3%) of those euthanased for mental illness were assessed as likely to die in the near term for just such reasons.[24]

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[23] 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

[24] https://overlegorganen.gezondheid.belgie.be/sites/default/files/documents/fcee-cijfers-2020_persbericht.pdf

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 psychological trauma at a very young age has been mentioned several times, such as domestic violence, psychological neglect or sexual abuse*.[25]

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.[26]

Depression is supposed to be screened for under the Oregon law. 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.[27]

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

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[25] 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

[26] 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

[27] 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

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.[28] 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.

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*

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

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 personally paid for this psychiatric consultation and that it in fact took less than 20 minutes.[29]

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".

Section 21 (1) (b) of the Bill requires a referral to "a registered health practitioner with the appropriate skills" to determine decision-making capacity but only where the assessing practitioner considers that he or she is unable to make this determination. There is no guarantee that all assessing practitioners will be aware of their lack of competence in making such a determination and make the required referral. There is nothing in this provision to lead to any expectation of better results than in Oregon or the Northern Territory.

And there is no provision in the Bill for any assessment of decision-making capacity at the time a lethal poison prescribed for "self-administration" is ingested. This may be weeks or even months after any assessment made during the request process. The person may have since lost decision-making capacity and ingest the lethal poison with less than full awareness and freedom. They may be cajoled, deceived, bullied, or even forced to ingest it. We will never know.

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

How many wrongful deaths by euthanasia or assistance to suicide under the Bill, of persons due to undiagnosed and untreated depression, and other mental illnesses affecting decision-making, would be too many?

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.

Section 13 of the Bill, while excluding euthanasia or assistance to suicide **only** because a person has a disability, also affirms that applicants with a disability may be given access to euthanasia or assistance to suicide if the person is held to be eligible under section 10 of the Bill.

Indeed, this would allow an assessing practitioner to conclude, under Section 10, that a person is eligible for euthanasia or assistance to suicide because the person has a disability which is expected to cause the person's death within 12 months.

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 burden on family, friends, or caregivers (54.2%) and the loss of control of bodily functions, such as incontinence and vomiting (366.9%) .[30] **These are all disability issues.**

The Bill defines "suffering" in section 10 (2) to include "mental suffering" thus establishing a subjective notion that would allow euthanasia and assistance to suicide for disability related issues such as these.

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

If we legalise euthanasia and assistance to suicide for incontinence, a loss of ability to engage in one's favourite hobby, a need to have others take care of your physical needs, a loss of

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

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.*** [31]

The Bill's provisions for determining decision-making capacity and voluntariness, including the assessing practitioner-initiated referrals under section 21, are not adequate to address these issues for people with disability.

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.

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

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, as well as to be a model at Milan's Fashion Week. She also contributed to a documentary opposing the proposal to legalise euthanasia in New Zealand.[32]

By legalising assistance suicide and euthanasia the Bill would pose a direct threat to the lives of Queenslanders with disabilities who may be assessed as eligible to request it. Assessing practitioners are more likely to agree that they are "*better off dead*" and to miss signs of depression or coercion.

Legalising assistance to suicide and euthanasia 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.

How many wrongful deaths by assistance to suicide and euthanasia under this Bill of Queenslanders with a disability would be too many?

Can we rule out coercion if we legalise assisted suicide?

Section 10 (1) (c) of the Bill would require that a request for euthanasia or assistance to suicide be made "voluntarily and without 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 euthanasia and assistance to suicide is made legal and normalised – with the decision to ask for euthanasia or assistance to suicide positively affirmed as a wise choice - will create a framework in which a person with low self-esteem, or who is more susceptible to the influence of others, may well express a request for euthanasia or assistance to 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.

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

Seniors Rights Victoria provides a useful summary of case law and best practice on undue influence in the financial abuse of elders.[33]

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 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.[34]

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.

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.* [35]

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.**

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

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

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

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.[36]

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.[37]

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% 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[38] 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?

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[36] 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

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

[38] https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf

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?" [39]

It is clear from this evidence that the Bill's requirements for assessing practitioners and witnesses to simply tick a box stating that the person requesting euthanasia or assistance to suicide is doing so voluntarily and without coercion is no guarantee that the practitioner or witness 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.

Section 21 (1) (c) of the Bill requires a referral to "a registered health practitioner with the appropriate skills" to determine whether the person "is acting voluntarily and without coercion" but only where the assessing practitioner considers that he or she is unable to make this determination. There is no guarantee that all assessing practitioners will be aware of their lack of competence in making such a determination and make the required referral.

Section 54 requires the witness to the act of euthanasia to certify that "the person appeared to be acting voluntarily and without coercion". The witness has no qualifications to do so. The witness could also be a family member who has been applying the coercion!

And there is no provision in the Bill for any assessment of voluntariness and absence of coercion at the time a lethal poison prescribed for "self-administration" is ingested. The person may have been cajoled, deceived, bullied, or even forced to ingest it. We will never know.

How many wrongful deaths of Queenslanders who are unduly influenced or coerced into requesting or ingesting a lethal poison would be too many?

Social contagion of suicide

By legalising assistance to suicide for some Queenslanders the Bill would undermine the commitment to **suicide prevention for all** Queenslanders.

By legalising assisted to suicide and euthanasia for a select group of Queenslanders, those diagnosed as terminally ill, the Parliament of Queensland would be affirming that such Queenslanders would be better off dead and supporting their suicide as a legitimate, rational choice to be facilitated rather than prevented like the suicides of all other Queenslanders.

[39] https://www.medscape.com/viewarticle/879187

How can publicly and openly offering assistance to commit suicide to one group of Queenslanders be reconciled with the public policy goal, widely shared across the whole community, to reduce the incidence of suicide?

As set out in *Our Future State*[40]

Suicide has devastating impacts on families, friends and communities. Over the past decade, an average of more than 600 Queenslanders each year have died by suicide. Suicide is the leading cause of death for Australians between 15 and 44 years of age. In 2015, the number of deaths by suicide (746) in Queensland was three times greater than the Queensland road toll (243).

What do we want to achieve? Reduce suicide rate by 50% by 2026.

However, scrutiny in an important study by David Albert Jones and David Paton, 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%.[41]

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 was subjected to careful scrutiny in the study by Jones and Paton, which compared trends in suicide rates in those states of the United States which have legalised assisted suicide compared to those which have not.[42]

The study, after controlling 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**.

[40] https://www.ourfuture.qld.gov.au/assets/custom/docs/gov-objectives.pdf
[41] https://pdfs.semanticscholar.org/6df3/55333ceecc41b361da6dc996d90a17b96e9c.pdf
[42] https://pdfs.semanticscholar.org/6df3/55333ceecc41b361da6dc996d90a17b96e9c.pdf

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.[43]

This conclusion is supported by **evidence from Victoria**.

When arguing for the legalisation of State-approved and funded assistance to suicide, then Minister for Health and Human Services, the Hon Jill Hennessy, claimed that:

Evidence from the coroner indicated that one terminally ill Victorian was taking their life each week.[44]

The *Voluntary Assisted Dying Act 2017*, which she introduced on behalf of the Victorian Government, excluded deaths by self-administration of a "voluntary assisted dying substance" for the purpose of causing a person's death from being considered as caused by suicide.

By this legal fiction, which is replicated in Section 8 of the Bill, such deaths are recorded as caused by the disease, illness or medical condition cited by a doctor in the application for a self-administration permit under the Victorian Act.

If Ms Hennessy's claim was correct there ought to have been **a decrease of around 50 deaths by suicide each year** once the Act came into operation, as it did on 19 June 2019, as these terminally ill Victorians would now have access to a State-approved and State-funded way to intentionally cause their own deaths by ingesting a lethal poison.

However, according to the Coroners Court of Victoria there were 694 deaths by suicide in Victoria in 2017.[45]

There were slightly more - 698 - in 2020, which was the first full calendar year in which State issued suicide permits and the State-funded poison delivery service were in operation.

So there is no evidence that the anticipated decrease of 50 deaths by (non-authorised) suicide each year has been achieved.

Moreover, if we put aside the legal fiction declaring suicides pursuant to a permit issued by the Victorian Secretary of the Department of Health and Human Services there were an

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

[44] https://www.parliament.vic.gov.au/images/stories/daily-hansard/Assembly_2017/Assembly_Daily_Extract_Thursday_21_September_2017_from_Book_12.pdf

[45] https://www.coronerscourt.vic.gov.au/sites/default/files/2021-01/Coroners%20Court%20Monthly%20Suicide%20Data%20Report%20-%20December%202020.pdf

additional 144 suicides in 2020 which were officially recorded by the Voluntary Assisted Dying Review Board as "Confirmed deaths - Medication [sic] was self-administered".

Adding these 144 State-approved, State-funded suicides by the ingestion of State-supplied lethal poison to the 698 suicides without such State approval and facilitation gives a total of 842 suicides in 2020 - an increase of 21.2% on 2017.

The 144 suicides with State approval in 2020 are nearly three times the 50 suicides of terminally ill persons each year claimed by Minister Hennessy during the 2017 parliamentary debate.

Additionally, 31 Victorians were killed by injection of State-funded and supplied lethal poisons by a doctor who had been issued, a voluntary assisted dying physician administered permit, by the Secretary of the Department for Health and Human Services, specifically **authorising the doctor to administer the poisons in order to cause the death of the person**.

If these are added to the count of suicides - insofar as they are at least purported to be **performed at the request of the person with the intention of causing that person's death** - then the total for 2020 would be 873 - a 25.8% rise since 2017.

How many wrongful deaths of Queenslanders by suicide contagion resulting from the legalisation, normalisation (and even glamorisation) of suicide for some Queenslanders brought about by the Bill would be too many?

Killed without request or while resisting

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.[46]

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

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

administration of an intravenous lethal injection. **She was physically restrained by family members while the doctor completed the administration of the lethal drugs**.[47]

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.[48]

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.

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**.[49]

Unfortunately, a subsequent decision of the Dutch Supreme Court not just exonerated the doctor in this case but effectively affirmed that forcible euthanasia of a person verbally and

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

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

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

actively resisting being killed was justified based on a valid advanced directive requesting euthanasia. [50]

The Bill does not explicitly allow euthanasia of persons who do not have or have lost decision-making capacity but, as explained above, its provisions are unable to guarantee that this does not occur.

Lacking decision-making capacity

In a landmark study of decision making capacity of persons with terminal cancer and a prognosis of less than six months to live [51] – that is a cohort that would be eligible for euthanasia or assistance to suicide under the Bill – 90% were found to be impaired in regard to at least one of the four elements of decision making – Choice (15% impaired), Understanding (44%), Appreciation (49%) and Reasoning (85%).

Under Section 11 (2) of the Bill, "a person is presumed to have decision-making capacity in relation to voluntary assisted dying unless there is evidence to the contrary".

This study suggests that, at least in the case of persons with cancer and a prognosis of less than six months to live, it would be more prudent to start from the presumption that they are likely to have impaired decision making capacity unless it is demonstrated to the contrary.

The study also found a significant discrepancy between physician assessments of decision-making capacity compared to the actual decision-making capacity as tested on the MacCAT-T scales.

Physicians assessed as "unimpaired" 64% of those who, according to the MacCAT-T assessment had impaired Reasoning; 70% who had impaired Appreciation; 61% who had impaired Understanding and 100% of those who had impaired Choice.

This lack of ability of physicians who are actually caring for terminally ill cancer patients with a prognosis of less than six months to live to accurately assess their patients' decision-making capacity is likely to be exceeded in flawed assessments of decision making capacity by other doctors – who do not necessarily have an established relationship with the person – making an assessment of decision making capacity in relation to a request for assisted suicide.

It will be practitioners such as this who will be making these assessments under the Bill.

As discussed above the optional referral for an expert assessment on decision-making capacity under section 21 (1) (b) of the Bill, is insufficient. In Oregon in 2018 only 3 out of 168 people (1.78%) who died by assisted suicide under the Oregon law were referred by the

[50] https://www.theguardian.com/world/2020/apr/21/dutch-court-approves-euthanasia-in-cases-of-advanced-dementia

[51] Elissa Kolva et al., "Assessing the decision making capacity of terminally ill patients with cancer", American Journal of Geriatric Psychiatry, 2018 May; 26(5): 523–531, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6345171/pdf/nihms937741.pdf

prescribing doctor to a psychiatrist or psychologist for consultation on whether or not the person was not "capable" due to "impaired judgement".[52]

Oregon and Washington report data on the **length of time** between a person **requesting** a lethal substance for the purpose of assisted suicide and **ingesting** the substance.

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). In Washington 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.

Clearly in these cases there is a real possibility that, even if a person was correctly assessed as having decision making capacity at the time of the request they may well have since become impaired in their decision making capacity before actually ingesting the lethal substance.

Under these schemes, as is the case in the Bill, the only assessment of decision-making capacity in relation to assistance to suicide, is carried out at the time of the request. There is no assessment of decision-making capacity at the time the lethal poison is ingested.

This obviously creates the opportunity for subtle or overt coercion, or for deceptive administration of the lethal substance by a family member or carer. However, it also makes it possible for the person to voluntarily ingest the lethal substance but without a full appreciation or understanding of what they are doing and without making a reasoned decision to do so.

Given that, even if Queensland practitioners have or improve their skills in assessing decision making capacity beyond that indicated in the study, there will still be persons who are mistakenly assessed as having decision making capacity who actually are impaired in their ability to understand, appreciate or make a reasoned decision about assistance to suicide or euthanasia, and there will inevitably be wrongful deaths from lack of capacity.

Additionally, as the Bill would allow persons requesting a lethal poison for assistance to suicide to be prescribed and supplied with the lethal poison for later ingestion there is a very real possibility that some of these people will have impaired decision-making capacity by the time (perhaps weeks, months or even years later) when they ingest it.

How much such wrongful deaths under the Bill would be too many?

52 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

INHUMANE DEATHS BY ASSISTED SUICIDE AND EUTHANASIA

The case for legalising assistance to 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.[53]

Deaths by assistance to 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, peaceful death.

Technical problems, complications and problems with completion in the administration of lethal drugs for euthanasia have been reported from the Netherlands.[54]

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

53 https://assets.nationbuilder.com/australiancarealliance/pages/139/attachments/original/1551911256/Sinmyee_et_al-2019-Anaesthesia.pdf?1551911256

54 https://assets.nationbuilder.com/australiancarealliance/pages/139/attachments/original/1551913544/CLINICAL_PROBLEMS_WITH_THE_PERFORMANCE_OF_EUTHANASIA_Netherlands.pdf?1551913544

where a first attempt at euthanasia failed and the doctor had to leave the person to get a second batch of lethal drugs.[55]

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.

[55] https://www.om.nl/onderwerpen/euthanasie/beslissingen-college/

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.

No scheme for assisted suicide and euthanasia so far enacted or proposed can guarantee a humane, rapid and peaceful death.

There is nothing in the Bill that points to a different outcome so some deaths under the Bill, will be slow, painful and inhumane, and therefore wrongful deaths. How many such wrongful deaths are too many?

QUEENSLAND COURT OF APPEAL DECISION ON AIDING SUICIDE: A RED FLAG TO CHANGING SECTION 311

In a unanimous decision by three judges of the Queensland Court of Appeal handed down in Brisbane on 19 June 2020 in the case of *R v Morant [2020] QCA 135*, Graham Morant's appeal against his conviction for aiding the suicide of his wife was rejected on all four grounds of appeal and the sentence of 10 years imprisonment was upheld as fair.

Morant was convicted on two counts under s311 of the Queensland Criminal Code. The first was that he had counselled Ms Morant to kill herself and thereby induced her to do so. The second was that he had aided her in killing herself.

One of the grounds of appeal was the belated discovery of two emails Ms Morant had exchanged with Dr Philip Nitschke. The emails presumably showed that she had suicidal ideation and was actively considering means of suicide.

However, these things were already apparent from evidence presented at Mr Morant's trial. As Sofronoff P concluded (at 38):

> *The evidence could not have helped the appellant. It would, instead, have reinforced Ms Morant's vulnerability to the appellant's inducements.*

Sofronoff P explains (at 47):

> *It was implicit in the jury's verdicts that the appellant had counselled Ms Morant to kill herself with the intention that she should commit suicide. It also follows that the jury found that the counselling was effective to induce her to commit suicide so that,*

> *but for the appellant's counselling, she would not have gassed herself on 30 November 2014.*

Morant stood to benefit from three life insurance policies to the total of $1.4 million.

His efforts to induce his wife to commit suicide included recounting to her a story about "*a customer of his [who] had taken out policies of insurance in favour of his wife and had then killed himself*." Mr Morant told his wife that that was "*an amazing and wonderful thing*" to have done. He encouraged her to do the same for him.

Sofronoff P concluded (at 64-65):

> *The present case is a paradigm case that exhibits **the wickedness** of the offence of counselling and thereby inducing a victim to kill herself. The offence was committed against a woman who was vulnerable to the appellant's inducements. His actions were premeditated, calculated and were done for financial gain… The offence was a serious one that involved a killing of a human being.*

One of the judges, Boddice J summarised (at 248-249) the case against Graham Morant:

> *[T]he deceased was a vulnerable person with difficulties with her physical health, who was already suffering depression; and the fact that the appellant, by his conduct, took advantage of those vulnerabilities in order to persuade her to kill herself and then assisted her to do so.*
>
> *In addition to those matters, the more serious aspect of the offences, counselling suicide, occurred over a period of months. Its seriousness was aggravated by the fact that the appellant had also aided the deceased to kill herself, being the end result of that extended period of counselling.*

This case should be **a big red flag** to the Committee in considering the Bill which would permit euthanasia and assistance to suicide.

Sections 20 and 31 of the Bill require the assessing practitioners to undergo "approved training" and section 165 (2) (c) would provide that this includes "identifying and assessing risk factors for abuse or coercion".

It is instructive to note that the approved training (prepared by Ben White) for doctors licensed to kill by lethal injection or to prescribe poison to people in Victoria under its euthanasia and assisted suicide law contains a total of **just over 5 minutes** (including a 2 minute 20 second video and slides which take a further 2 minutes 50 seconds to read) assessing voluntariness, including assessing the absence of coercion.

As a co-author of "an article entitled "Biggest decision of them all – death and assisted dying: capacity assessments and undue influence screening", published in the *Internal Medicine Journal* in January 2019, White dissented from the recommendations of his co-authors proposed "*Guideline for clinicians assessing capacity and screening for undue Influence for voluntary assisted dying".*

Issues identified in this insightful report but **completely ignored in the training prepared by White** for Victorian doctors include:

- *undiagnosed depression;*
- *cognitive impairment associated with Motor Neuron Disease and its effect on decision making capacity;*
- *the use of supported decision making "*allowing one person to communicate or assist with communicating another's decision raises concerns about potential for undue influence, especially given the gravity of the assisted suicide or euthanasia decision".

This Bill, if passed, would remove from vulnerable Queenslanders like Ms Morant, the protection of Section 311 with its absolute and universal prohibition on counselling, inducing and aiding suicide.

Instead manipulative, greedy, coercive, murderous perpetrators like Graham Morant, will simply need to suggest to a vulnerable spouse or parent or "friend" that accessing legal doctor provided euthanasia or taking doctor prescribed lethal poison is "*all for the best dear*".

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.

How will such a scheme avoid wrongful deaths?

How will such a 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.

And our analysis of the *Voluntary Assisted Dying Bill 2021* confirms that there is nothing in the proposed Queensland regime that would make it any more successful at excluding wrongful deaths, and some provisions that would make such wrongful deaths more frequent.

Based on this evidence we urge the Committee to recommend that as the Bill is likely to lead to the wrongful deaths of some Queenslanders it ought not be passed.