



Australian
CareAlliance

“Care and Compassion: Opposing Assisted Suicide.”

Submission to the Standing Committee on Law and Justice, Parliament of New South Wales on the Provisions of the *Voluntary Assisted Dying Bill 2021*

from the Australian Care Alliance

EXECUTIVE SUMMARY

Any Bill to change the law on murder and on aiding, abetting, inciting or counselling another person to commit suicide by creating broad exemption from these laws for doctors and nurses who prescribe or administer a lethal poison to a specified category of persons requires the most careful scrutiny.

The *Voluntary Assisted Dying Bill 2021* is such a Bill.

The core of the Bill is making legal the act of prescribing a Schedule 4 or Schedule 8 poison in sufficient dose to cause the death of a person with the intention that the person either has the lethal poison administered to him or her or self-administers it.

Part 9 of the Bill makes it clear beyond doubt that acts done in accordance with the Bill are immune from any criminal liability, effectively providing **exceptions to the criminal law on murder and on aiding, abetting, inciting or counselling another person to commit suicide 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, Canada and Victoria 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

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 New South Wales; 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 treatment. (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 disabilities have been told by a doctor that they would be better off dead. The Bill validates that discriminatory attitude. (Example: Belgium and the Netherlands allow euthanasia for intellectual disabilities such as Asperger’s and physical disabilities such as blindness.)
8. **Coercion** -- 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

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

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 suicide 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 significant complication rate and do not guarantee a peaceful, rapid, painless 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 ($\leq 9\%$), a relatively high incidence of vomiting ($\leq 10\%$), prolongation of death (by as much as seven days in $\leq 4\%$), and failure to induce coma, where patients re-awoke and even sat up ($\leq 1.3\%$). 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

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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 the provisions of the Bill. 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 7 of the Bill defines a “**voluntary assisted dying substance**” to be “a Schedule 4 poison or Schedule 8 poison” approved by the Health Secretary “for use under this Act for the purpose of causing a patient’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 solely to acts directed at the administration of a poison in a sufficient dose to cause death.

Section 57 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 a medical practitioner, nurse practitioner or registered 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.

Crimes Act 1900 s18: intent to kill

The key element of the crime of murder, as defined in s18 of the *Crimes Act 1900*, is that “*the act of the accused, causing the death charged, was done with intent to kill*”.

This is also the key element of an act of practitioner administration under Clause 60 this Bill.

Section 27 of the *Crimes Act 1900* makes it an offence to do an act to a person with intent to murder the person.

That section reads in part:

Whosoever administers to, or causes to be taken by, any person any poison ... with intent in any such case to commit murder, shall be liable to imprisonment for 25 years.

Clause 137 of the Bill would provide complete immunity from prosecution for murder or attempted murder and from prosecution for abetting murder, for:

- the medical practitioner, nurse practitioner or registered nurse who administers the poison;
- the witness to an act of practitioner administration;
- the medical practitioner who prescribes the poison;
- the pharmacist who provides the poison; and
- the public servant who issues an authority for the prescription of the poison for the purpose of being administered to a person in order to cause the person's death.

Section 31C of the *Crimes Act 1900* prohibits aiding, abetting, inciting or counselling another person to commit suicide.

Making it lawful for a medical practitioner 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.

In relation to the offence of *inciting or counselling suicide* the Bill would provide immunity – an exception – for the following people and actions:

- any health care worker – including a disability care worker - if asked by the person for information “about voluntary assisted dying” (Clause 10 (4)) may go on to incite or counsel the person to make use of the provisions of the Bill to self-administer a poison in a sufficient dose to cause the person's death.

A health care worker or disability worker who initiates a discussion or make a suggestion about using the provisions of the Bill to self-administer a poison in a sufficient dose to cause the person's death – that is **plants the idea in the mind a person to whom they are providing care**, including intimate personal care, that the person would be better off dead and should take steps to achieve that end; This immunity is subject only to the health care worker or disability worker, at the same time as **planting the idea of suicide**, making **some mention** of possible palliative care and treatment options – about which the carer may have no expertise whatsoever – and suggesting the person should discuss these with their doctor.

- any medical practitioner or registered nurse who suggests suicide even when not asked by the person has immunity, subject only to at the same time informing the person of information about treatment options and palliative care and treatment options and their likely outcomes (noting that this provision applies to any medical practitioner or registered nurse without any requirements for experience or qualifications beyond basic registration);
- any person – including a family member - who incites or counsels a person to request prescription of a poison for the purpose of causing the person’s death or, once the poison is prescribed, incite or counsel the person to self-administer it has complete immunity from the *Crimes Act 1900* offence of inciting or counselling suicide.
- Clause 124 and 125 of the Bill would create new offences of inducing a person to make requests for or to self-administer a poison in order to cause the person’s death but limits the offence to instances where the inducement is done by “*dishonesty or pressure or duress*”. “*Pressure or distress*” is defined in the Dictionary of the Bill to mean “*abuse, coercion, intimidation, threats and undue influence*”.
- This still leaves wide scope for making suggestions – including planting the idea in the head of a person who would otherwise never have considered this course of action.
- Immunity from any criminal liability would be given by the Bill to persons whose actions would otherwise be considered as offences of “*Aiding or abetting suicide*” such as:
 - the medical practitioner who prescribes the poison, the pharmacist who provides the poison and the public servant who issues an authority for the prescription of the poison;
 - the contact person or agent who collects the poison from the pharmacist and supplies the poison to the person; and
 - any person who prepares the poison for the person to self-administer.

The Bill would make these profound changes to the operation of the *Crimes Act 1900*.

Accordingly, as it would create exceptions to the laws prohibiting both murder and aiding, abetting, inciting or counselling another person to commit suicide, 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?”

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, tick - all four 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.

³ <https://youtu.be/VvsN47Uqbt0>

⁴ <https://www.medscape.com/viewarticle/879187> [Free registration required to view article]

The Bill is built on the assumption that simply because two doctors have ticked a box that a person has a terminal illness, will “on the balance of probability” die within six 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 New South Wales 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 New South Wales, including in Aboriginal and remote communities, have equitable access to those treatments
- 4) World's best practice palliative care is available to every person in New South Wales, including in Aboriginal and remote communities
- 5) No person in New South Wales 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

So much in the Bill is premised on the evidently unfounded and dangerous assumption that just because a box is ticked the statement next to the ticked box represents the actual truth of the situation.

It mistakes the fact that two assessing medical practitioners profess that they are “*satisfied*” that the patient meets all the eligibility criteria with the separate factual question of whether this is actually the case.

One of the eligibility criteria in Clause 16 (1) (d) is that a person “*is diagnosed with at least 1 disease, illness or medical condition that is advanced, progressive and will cause death*”.

Two medical practitioners may be honestly satisfied that such a diagnosis has been made.

Neither is required to make this diagnosis themselves. Nor does the bill impose a formal requirement for a second opinion based on a fresh confirmation of an initial diagnosis.

Both of the two assessing medical practitioners can rely on the same initial diagnosis.

Unlike the provisions in the Voluntary Assisted Dying Act 2017 in Victoria, neither medical practitioner is required to have any particular experience or qualifications in the relevant “*disease, illness or medical condition*”.

There is no provision in the Bill for who is to make or to have made the diagnosis. Nor is there any requirement on either medical practitioner to investigate how the diagnosis was made.

The medical practitioner “*may have regard to relevant information about the patient that has been prepared by, or at the instigation of, another registered health practitioner*” (Clause 25 (3))

The medical practitioner could be unable to decide if the person has “*at least 1 disease, illness or medical condition that is advanced, progressive and will cause death*”. If so, the medical practitioner *must refer the patient to a medical practitioner who has appropriate skills and training to make a decision about the matter*.

But when the report from this referral is received the medical practitioner *may* (and therefore *may not*) adopt the decision.

In any case it will only ever be the medical practitioner **who in his or her own mind is “unable to decide”** who makes such a referral. No-one else – including the Review Board – can see inside that mind.

So this provision fails to protect a person from a medical practitioner who is less thorough, more self-confident, more ready to positively assess any application for access under the Bill by declaring that he or she is satisfied the person has a relevant diagnosis of *“at least 1 disease, illness or medical condition that is advanced, progressive and will cause death”*.

In a 2017 article on *“Diagnostic error, overconfidence and self-knowledge”*, Quassim Cassam found that *“physician overconfidence is a major factor contributing to diagnostic error in medicine.”*

He also explained that *“The hypothesis that diagnostic errors due to overconfidence can be remedied by increasing physician self-knowledge is shown to be questionable. Some epistemic vices or cognitive biases, including overconfidence, are “stealthy” in the sense that they obstruct their own detection.”*⁵

This has serious consequences for the operation of this Bill.

The decision to refer to a specialist for confirmation of a diagnosis rests entirely with the assessing medical practitioner. Where this medical practitioner is unaware of his or her “overconfidence” it is unlikely that he or she will conclude that he or she will conclude that they are unable to decide whether the person meets the eligibility criteria and consequently decisions based on a mistaken diagnosis are likely to be made.

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.”*⁶

⁵ <https://www.nature.com/articles/palcomms201725#auth-Quassim-Cassam>

⁶ <http://www.stuff.co.nz/national/politics/84252580/euthanasia-toofinal-when-the-risk-of-error-is-to-great--doctors>

Ten per cent of cases in Australia are misdiagnosed according to Peter McClennan, chief executive at Best Doctors.⁷

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, *“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”*.⁸

One German study found that on autopsy, for about 10% of all clinically diagnosed cancer cases no cancer was found to exist.⁹

A false positive diagnosis of cancer can lead to unnecessary anxiety but in some cases also to unnecessary treatment, which can have lasting bad effects on a patient’s well-being.

False positives can result from a range of human errors, such as misinterpretation of biopsy slides, mislabelling of samples – the wrong person being told they have cancer – as well as inherent uncertainties in every diagnostic tool.

Once we bring legalised assisted suicide and euthanasia into the picture – as this Bill would do – there is the real, inevitable and unavoidable possibility that a false positive diagnosis of cancer (or any other terminal disease, illness or medical condition) will lead to a person dying prematurely and unnecessarily.

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.¹⁰ 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

⁷ <https://amp.afr.com/business/insurance/insurance-companies/mlc-life-to-expand-best-doctors-service-20170827-gy4zfk>

⁸ 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>

⁹ <https://pubmed.ncbi.nlm.nih.gov/7224822/>

¹⁰ <https://www.kansascity.com/news/business/health-care/article216764080.html>

a diagnosis by both Italian and Swiss doctors prior to undergoing assisted suicide in Switzerland.¹¹

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.

Clause 26 of the Bill requires a referral to “a medical practitioner who has appropriate skills and training” to determine whether the person has “a disease, illness or medical condition that ... will cause death” but only where the coordinating 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.

Under Schdeule 1A.1 item [1] of the Bill, any death certificate issued by the Registrar of Births, Deaths and Marriages will state that the person died of the diagnosed condition although the real cause of death is lethal poisoning.

Any claim in the future that there have been no wrongful deaths by misdiagnosis under this 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 six months to live when they may have many years of life ahead of them** then that is a wrongful death – with no remedy.

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

Clause 16 (1) (d) (ii) of the Bill would provide for two medical practitioners profess to be satisfied that the person has a disease, illness or medical condition that “*will, on the balance*

¹¹ <https://www.thelocal.ch/20130711/assisted-suicide-in-question-after-botched-diagnosis>

of probabilities, cause death - for a disease, illness or medical condition that is neurodegenerative—within a period of 12 months, or otherwise—within a period of 6 months”.

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*”.¹²

Another [paper](#) describes doctors’ ability at predicting survival at 1 year as “*only slightly better than a random guess*”.¹³

[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.¹⁴

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.**

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.¹⁵

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

¹² <https://www.sciencedirect.com/science/article/pii/S0895435696003162>

¹³ <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0161407>

¹⁴ <http://www.bmj.com/content/bmj/320/7233/469.full.pdf>

¹⁵ Washington State Department of Health, *Death with Dignity Act Reports, 2009-2017* available at: <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>

request and ingestion recorded is 1009 days (that is 2 years and 9 months).¹⁶ Evidently in these cases the prognosis was wildly inaccurate.

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

Oregon's assisted-suicide law applies to patients predicted to have less than six months to live. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live. This was based on her not being treated for cancer.

At our first meeting, Jeanette told me that she did not want to be treated, and that she wanted to opt for what our law allowed – to kill herself with a lethal dose of barbiturates.

I did not and do not believe in assisted suicide. I informed her that her cancer was treatable and that her prospects were good. But she wanted "the pills." She had made up her mind, but she continued to see me.

On the third or fourth visit, I asked her about her family and learned that she had a son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated, and her cancer was cured.

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

For her, the mere presence of legal assisted suicide had steered her to suicide.¹⁷

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.

Clause 26 of the Bill requires a referral to "a medical practitioner who has appropriate skills and training" to determine whether the person has "a disease, illness or medical condition that ... will, on the balance of probabilities, cause death— for a disease, illness or medical condition that is neurodegenerative—within a period of 12 months, or otherwise—within a period of 6 months" but only where the coordinating practitioner considers that he or she is unable to make this determination. There is no guarantee that all assessing practitioners will

¹⁶ 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>

¹⁷ 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

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 6 months to live, but may have lived for years, would be too many?

Unaware of or unable to access effective treatment

Some supporters of the Bill appear to believe that access to its provisions permitting the prescription for self-administration or administration by a medical practitioner, nurse practitioner or registered nurse of a Schedule 4 or Schedule 8 poison in sufficient dose to cause death will only be allowed as a last resort after all treatment options have been exhausted.

There are no provisions in the Bill to ensure that this is the case.

Clause 10 (3) allows a health care worker or disability worker to actively propose death by lethal poison to a person they are providing care to without any indication that the person may otherwise have ever considered this option.

Oddly, the only alternative option to death by lethal poison that the carer is required to mention is “palliative care and treatment”. **There is no requirement to mention that there may also be treatment options.**

Clause 10 (2) does require medical practitioners when planting the suggestion of a person ending their life by administration of a lethal poison in the mind of a patient who has never indicated any interest or inclination to prematurely end their life in this way to also mention *“the treatment options available to the person that would be considered standard care for the disease, illness or medical condition with which the person has been diagnosed and the likely outcomes of the treatment options available to the person”*.

Of course, as this may be a medical practitioner fresh out of medical school or with a specialty completely removed from the relevant *“disease, illness or medical condition”*, then there is no reason to assume that this information will be accurate, up-to-date, balanced and comprehensive.

Clause 28 requires a co-ordinating practitioner after being satisfied that that a person meets the eligibility criteria for accessing death by lethal poison must inform the person of:

the treatment options available to the patient that would be considered standard care for the disease, illness or medical condition with which the patient has been diagnosed and the likely outcomes of treatment.

Clause 39 requires the same information to be provided by a consulting practitioner after coming to the same state of satisfaction about the person’s eligibility.

Clause 18 provides that:

A medical practitioner is eligible to act as a coordinating practitioner or consulting practitioner for a patient if the medical practitioner holds specialist registration, or holds general registration and has practised the medical profession for at least 10 years as the holder of general registration, or is an overseas-trained specialist who holds limited registration or provisional registration.

The corresponding Victorian *Voluntary Assisted Dying Act 2017* provides in Section 10 (3) that:

Either the co-ordinating medical practitioner or each consulting medical practitioner must have relevant expertise and experience in the disease, illness or medical condition expected to cause the death of the person being assessed.

This provision is intentionally absent from this Bill.

The necessary consequence is that neither of the two medical practitioners required to inform the person of their treatment options and their likely outcome will may have the qualifications, knowledge and experience to do so accurately, fairly or comprehensively.

No doubt conscientious medical practitioners do their best to keep up to date with the latest developments across medicine, but there are several reasons why both of the two medical practitioners required to provide this information may not communicate vital information that could lead the person to seek effective treatment for the disease, illness or medical condition they have been diagnosed with.

Medicine is a very broad field with new treatments being developed all the time and new studies providing updated evidence on “likely outcomes” of known treatments.

It is impossible for non-specialists to keep up to date with all relevant developments. That is why referral to relevant medical specialists for expert advice and treatment is such a key part of good medical practice.

The issue of “over-confidence” has been identified as a factor in some medical practitioners failing to refer for a second opinion n or for specialist advice or treatment for a patient. The nature of “over-confidence” often includes a lack of awareness by the professional of its existence and therefore the various optional referrals provided for in this Bill may be of little use.

Evidence from other jurisdictions, including some where a specialist in the relevant condition must be involved, shows that wrongful deaths by assisted suicide or euthanasia have occurred where a person could well have benefited from an available treatment but was never offered it.

Out of the four deaths under the Northern Territory’s short lived euthanasia laws one of those who died by euthanasia would have benefited from radiotherapy or strontium but neither of

these was available in the Northern Territory. Another could have been helped by stenting for obstructive jaundice or the management of bowel obstruction.

However, Dr Nitschke who euthanased this person, admitted to having *“limited experience, not having been involved in the care for the dying before becoming involved with the” euthanasia law.*¹⁸

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.**¹⁹

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.

Canada is one jurisdiction which allows euthanasia.

A study of 45 people who were euthanased at Ottawa Hospital for lung cancer showed that in 13 cases (28.9%) there was no confirmation of the condition by biopsy - an otherwise standard diagnostic procedure. In 10 cases (22%) there was no consultation at any stage with a medical oncologist to discuss prognosis and treatment options.

The time between diagnosis and euthanasia being performed was as short as 3 weeks.

Under the provisions of this Bill the time between a first request – which can be made immediately following an initial diagnosis of a terminal illness – and death by administration of a prescribed lethal poison may be as short as six days (or even shorter in some circumstances).

Treatments for lung cancer have improved considerably over the last few years leading to a reduction in mortality and an increase in the five year survival rate which is now 21.7%, according to the (US) National Cancer Institute.²⁰

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

¹⁹ http://www.euthanasiecommissie.nl/Images/RTE.JV2011.ENGELS.DEF_tcm52-33587.PDF

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This study demonstrates that when we legalise the intentional ending of life by euthanasia the inevitable result is the premature and unnecessary deaths of people who miss out on effective, helpful treatment that could have given them further years of life.

In some cases this will be due to a failure of the medical practitioners assessing them for access to euthanasia to have the specialist knowledge to properly and comprehensively advise the person on the most recent treatment options.

Another important aspect is the risk that when first diagnosed with a supposedly terminal illness a person may immediately request euthanasia and be granted it quickly.

This study shows that this has happened as few as 3 weeks after diagnosis. It could be as short as 6 days under this Bill. This does not allow any time for the person to process the new situation, to receive treatment for clinical depression or to be given time to reflect and consider treatment options.

The study was carried out by Dr Sara Moore and the results presented on 9 September 2021 at the 2021 World Conference on Lung Cancer.²¹

Dr Moore said

Biomarker-driven targeted therapy and immunotherapy offer effective and tolerable new treatments, but a subset of patients undergo medical assistance in dying [euthanasia] without accessing -- or, in some cases, without being assessed for -- these treatment options.

Given the growing number of efficacious and well-tolerated treatment options in lung cancer, consultation with an oncologist may be reasonable to consider for all patients with lung cancer who request medical assistance in dying.

Commenting on the presentation, geriatric and palliative care physician, Dr Monica Malec observed that:

Patients are seeking this option [euthanasia] despite the availability of more effective and more tolerable treatment options.

Existing literature suggests that loss of autonomy, control, and dignity are the primary drivers for seeking medical assistance in dying rather than uncontrolled symptoms, and the decision to pursue medical assistance in dying [euthanasia] may occur pre-illness.

This Bill utterly fails to ensure that no person is put to death or helped to commit suicide by the State-approved prescription and supply of a lethal poison when the person may have benefited from effective, life-saving treatments.

²¹ https://library.iaslc.org/conference-program?product_id=24&author=Grace+Yang

The requirements the Bill imposes on a practitioner when proposing euthanasia or assistance to suicide (Clause 10 (2)) to a person and before accepting a request for euthanasia or assistance to suicide (Clauses 28 and 39) to inform the person of “*the treatment options that would be considered standard care for the disease, illness or medical condition with which the patient available to the person and the likely outcomes of 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 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.”](#)²²

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

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

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.²³

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 person in new South Wales deserves access to gold standard palliative care which can alleviate pain, including using palliative sedation as a last resort.

The Australian and New Zealand Society of Palliative Medicine in its November 2021 position statement on "The Practice of Euthanasia and Physician-Assisted Suicide"²⁴ makes a number of observations that are very pertinent to our consideration of this Bill.

The statement notes that "*Palliative Medicine is the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life*".

This means that this society is made up of experts in the care of those for whom this Bill proposes the intentional ending of life by administration of a lethal poison as an appropriate response.

The statement declares:

Palliative Care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. In accordance with best practice guidelines internationally, the discipline of Palliative Medicine does not include the practices of euthanasia and physician-assisted suicide.

²³

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

²⁴ <https://www.anzspm.org.au/c/anzspm?a=sendfile&ft=p&fid=1635983800&sid=>

ANZSPM does not support the legalisation of euthanasia and physician-assisted suicide.

ANZSPM's position, based on the expertise and experience of its members, is that "good quality care for the dying ... does not include the practice of euthanasia or physician-assisted suicide".

Helpfully the statement clarifies that certain good medical practices in end-of-life care are not euthanasia or physician-assisted suicide because they do not – unlike the measures to be authorised by this Bill - involve acts done for the purpose of intentionally ending a person's life

These good medical practices which are not euthanasia or physician-assisted suicide – and would not be covered by this Bill's definition of "voluntary assisted dying", include:

- The refusal of life-sustaining treatments by the patient;
- Withholding or withdrawing treatments that are not benefitting the patient;
- Treatment that is appropriately titrated to relieve symptoms and has a secondary and unintended consequence of hastening death; and
- Palliative sedation for the management of refractory symptoms.

All these end-of-life practices are already lawful in NSW and that this Bill has no effect one way or the other on their legality.

The ANZSPM statement also comments on an appropriate response when a patient requests euthanasia or physician-assisted suicide:

Requests for euthanasia or physician-assisted suicide should be acknowledged with respect and be extensively explored in order to understand, appropriately address and if possible, remedy the underlying difficulties that gave rise to the request. Appropriate ongoing care consistent with the goals of Palliative Medicine should continue to be offered.

When requests for euthanasia or physician-assisted suicide arise, particular attention should be given to gaining good symptom control, especially of those symptoms that research has highlighted may commonly be associated with a serious and sustained "desire for death" (e.g. depressive disorders and poorly controlled pain). In such situations, early referral to an appropriate specialist should be considered.

This is what the experts in end-of-life care recommend.

If this Bill is passed this way, caring approach will be ridden over roughshod by a clumsy, ill-thought out approach that will put a person expressing a desire for help to end their life on a conveyor belt towards death by lethal poison.

When a palliative medicine specialist who, in accordance with this statement and the views of his profession on what is and is not good medical practice in end-of-life care will not participate in providing euthanasia or physician-assisted suicide, has a patient who requests euthanasia or physician-assisted suicide, he or she would be legally required by Clause 21 of the Bill to:

give the patient the information approved by the Health Secretary, by Gazette notice, for the purposes of this section.

If the palliative medicine specialist considers his or her objection to prescribing a lethal poison for a patient to be a matter of conscience – required by his professional obligation to engage in good medical practice – then he or she must hand over this information as soon as the request is made by the patient.

In any case if he or she decides to refuse the request to prescribe and perhaps administer a lethal poison to the patient, the patient must be given the information within 2 business days.

The gazetted information under the corresponding law in Western Australia is a 16 page booklet or a 17 minute audio file outlining the legal processes. It prominently features contact details for the Orwellian sounding “Western Australian Voluntary Assisted Dying Statewide Care Navigator Service”.²⁵

The only care offered by these navigators is assistance to suicide or death by administration of a lethal poison.

This compulsory provision of suicide facilitation information by a palliative medicine specialist – indeed any medical practitioner - to a patient with suicidal ideation cuts right across the wise and compassionate measures recommended in the Statement.

This includes advice that:

particular attention should be given to gaining good symptom control, especially of those symptoms that research has highlighted may commonly be associated with a serious and sustained "desire for death" (e.g. depressive disorders and poorly controlled pain). In such situations, early referral to an appropriate specialist should be considered.

Palliative medicine specialists treat an expressed “*desire for death*” as a possible symptom of a depressive disorder that may well respond to expert treatment.

The Bill would require medical practitioners to treat such an expressed desire as the first step in a bureaucratic, legalistic process that starts with handing them over to the “*official voluntary assisted dying care navigator service*” which can be gazetted under Clause 185 of this Bill and ends with their death by lethal poison.

²⁵ <https://ww2.health.wa.gov.au/~media/Corp/Documents/Health-for/Voluntary-assisted-dying/Approved-information-for-a-person-making-First-Request.pdf>

The ANZSPM statement properly notes that a desire for death driven by poorly controlled pain should be responded to by referral to an appropriate specialist to address the pain control.

Disturbingly the Bill undermines the important message palliative care experts are striving to inculcate throughout the medical and health care sector: Where pain and other symptoms associated with a life limiting illness – whether terminal or otherwise – are not able to be adequately managed by the primary care practitioner then a referral to a palliative care service must be made.

The Bill (in Clauses 10 and 28) seems to be premised on a patently false assumption that every medical practitioner is well enough informed about palliative care to be legally entrusted with the duty of informing a person expressing a desire for death, including where it is related to concern about inadequate pain control about:

the palliative care and treatment options available to the person and the likely outcomes of the palliative care and treatment options.

The reality is that palliative care is a specialist discipline of medicine which, like many areas of medicine, is constantly improving and about which many GPs and specialists in other areas of medicine will simply not be sufficiently up-to-date, informed or experienced to convey an accurate and comprehensive account of the palliative care options and their likely outcomes to a person.

While the better, more prudent and less self-confident medical practitioners may be aware of this defect in their knowledge base and make an appropriate referral, the less wise and more obviously self-confident medical practitioners will happily tick the box on the forms sent to the government Board stating that all this important information has been provided.

There is no mechanism in the Bill for verifying the quality of the information on palliative care information given to a person before a VADSA – a “voluntary assisted dying substance authority” is issued by the government appointed bureaucrats under Clause 71 of the Bill permitting the suicide or euthanasia of the person by administration of a prescribed lethal poison.

This means it is absolutely certain – inevitable – that some people will die by lethal poison – having been authorised to do so by the State of NSW – when proper access to palliative care and treatment would have relieved their concerns about inadequate control of pain or other physical symptoms.

As the Australian Pain Management Association has warned legalising assisted suicide or euthanasia “*may lead to government having an opportunity for people to end their life with the help of another person rather than investing in early pain management support and the*

*medical treatment and community support that people need in order to have a ‘good death’ and die with dignity”.*²⁶

Another significant observation in the ANZSPM statement points to inequities in current access to gold standard palliative care.

ANZSPM acknowledges the significant deficits in the provision of palliative care in Australia and New Zealand, especially for patients with non-malignant life-limiting illnesses, those who live in rural and remote areas, residents of Residential Aged Care Facilities, the indigenous populations and those from culturally and linguistically diverse backgrounds

Each of these deficits gives rise to a serious concern about the recklessness of legislating to facilitate the intentional ending of a person’s life in the absence of ready access to need palliative care.

New South Wales is a large state and the challenges of delivering the full range of health care, including palliative care, in regional and rural NSW are well-known.

The gap between Aboriginal and non-Aboriginal residents of NSW in life expectancy and in access to health care is one we should be doing our utmost to bridge as quickly as possible.

When the Queensland Parliament recently passed its Voluntary Assisted Dying Bill 2021, respected indigenous leader Noel Pearson was not among those who cheered its passage.²⁷

He cited Yawungu man and WA Senator Pat Dodson’s comment that:

Where First Nations people are already overrepresented at every stage of our health system, it is irresponsible to vote in favour of another avenue to death. Paving the way for euthanasia and assisted suicide leaves First Nations people even more vulnerable, when our focus should be on working collectively to create laws that help prolong life and restore their right to enjoy a healthy life.

All those concerned with the gap in life expectancy and the provision of health services for Aboriginal people in NSW should oppose the Bill.

The third deficit in the availability of palliative care pointed to in the statement by ANZSPM is in “Residential Aged Care Facilities”.

On this topic the Bill is frankly chilling.

The Bill would prevent any residential aged care facility in NSW from being a safe zone where residents could be assured that no lethal poisons would be used for residents to commit suicide with State approval and no medical practitioner, nurse practitioner or

²⁶ <https://www.painmanagement.org.au/>

²⁷ https://www.australiancarealliance.org.au/opposed_pearson

registered nurse would come onto the premises to put a resident to death by administering a lethal poison.

However, the Bill would do absolutely nothing to remedy the deficit identified by ANZSPM in access to palliative care by residents in aged care facilities.

While these deficits in access to gold standard palliative care it would be reckless to support legislation to facilitate access to death by lethal poison.

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](#)²⁸ and [Randy Stroup](#),²⁹ 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.³⁰

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

²⁸ <https://abcnews.go.com/Health/story?id=5517492>

²⁹ <http://www.foxnews.com/story/2008/07/28/oregon-offers-terminal-patients-doctor-assisted-suicide-instead-medical-care.html>

³⁰ https://www.australiancaralliance.org.au/canada_assisted_suicide_not_assisted_living

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.³¹

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?

Victoria does not report data on the reasons people have requested assisted suicide or euthanasia under its law. However, a small study by Dr Cameron MacLaren et al. found that a concern about the financial implication of treatment was a reason in 1.7% of cases.

While we are privileged to have a nationally funded Medicare system, reasonably well-funded public hospitals and the NDIS to provide financial support for disability care, there are still people in New South Wales, including those in regional and rural New South Wales, residents of aged care facilities, Aboriginal people and – despite the NDIS – people with disabilities who may not have access to expensive but effective treatment and care.

The economic rationalist, cost saving approach of a premature death by lethal poison that would be facilitated by this Bill is not one that should be supported.

The Bill would permit euthanasia or assistance suicide with no guarantee that not a single person in NSW 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.

Clause 16 (2) (b) of the Bill would provide that: “A person is not eligible for access to voluntary assisted dying **merely** because the person has a mental health impairment within the meaning of the Mental Health and Cognitive Impairment Forensic Provisions Act 2020.”

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

The key word in this provision is the word “merely” which constrains its operation to very narrow circumstances.

The *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* provides that a *person has a mental health impairment if:*

- (a) the person has a temporary or ongoing disturbance of thought, mood, volition, perception or memory, and*
- (b) the disturbance would be regarded as significant for clinical diagnostic purposes, and*
- (c) the disturbance impairs the emotional well-being, judgment or behaviour of the person.”*

So the effect of Clause 16 (2) (b) is simply that the Bill would not authorise the self-administration or administration by a medical practitioner, nurse practitioner or registered nurse of a lethal poison merely because the person has a mental health impairment.

However, the Bill does not exclude the administration of a lethal poison to a person with a mental health impairment if they meet the eligibility criteria set out in the Bill.

There are two distinct circumstances that this allows.

Firstly, a person with a mental health impairment – including a very severe mental health impairment affecting the person’s judgement – who has a physical “disease, illness or medical condition” that “on the balance of probabilities” may cause death within six months could access the Bill.

Clause 6 provides a presumption that a person has decision-making capacity unless shown not to have it. It also defines decision-making capacity in relation to cognitive processes – understanding, remembering, weighing up and communicating.

This definition would allow a person who was profoundly depressed to still be assessed as having the requisite decision-making capacity to choose to end their life or have their life ended by administration of a lethal poison.

The second circumstance allowed by Clause 16 (2) (b) is where a mental health impairment – such as bipolar disorder for example – could be considered as a “disease, illness or medical condition” that “on the balance of probabilities” will cause death within six months” based on, say, a history of repeated attempts at suicide and a resistance to treatment by a psychiatrist.

The evidence from other jurisdictions that have legalised euthanasia or assisted suicide shows that people with a mental illness are at risk of wrongful death under any law authorising assisted suicide or euthanasia.

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.³²

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.*³³

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.³⁴

However, of the 1905 people who have died by ingesting lethal dose prescribed under the Act only 69 (3.6%) were first referred for psychiatric evaluation.

This means **as many as 248 people with depression may have been helped to commit suicide** without any such referral.

In 2011 Dr. Charles J. Bentz has cited the example of a 76-year-old patient he referred to a cancer specialist for evaluation and therapy. The patient was a keen hiker and as he

³² https://overlegorganen.gezondheid.belgie.be/sites/default/files/documents/fcee-cijfers-2020_persbericht.pdf

³³ 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

³⁴ 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>

underwent therapy, he became depressed partly because he was less able to engage in hiking.

The most common reason for requesting assisted suicide in Oregon is a concern about being less able to participate in enjoyable activities.

The patient expressed a wish for assisted suicide to the cancer specialist, who rather than making any effort to deal with the patient's depression, proceeded to act on this request by asking Dr Bentz to be the second concurring physician to the patient's request.

When Dr Bentz declined and proposed that instead the patient's depression should be addressed the cancer specialist simply found a more compliant doctor for a second opinion.

Two weeks later the patient was dead from a lethal overdose prescribed under the Act.

Dr Bentz concludes:

In most jurisdictions, suicidal ideation is interpreted as a cry for help. In Oregon, the only help my patient got was a lethal prescription intended to kill him."

He has urged other jurisdictions "Don't make Oregon's mistake."³⁵

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

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

[Case studies on these four deaths have been published.](#)³⁶ 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.

³⁵ <http://blogs.theprovince.com/2011/12/05/province-letters-icbc-egypt-assisted-suicide-oregon-christmas-pre-marital-sex/>

³⁶ https://d3n8a8pro7vhmx.cloudfront.net/australiancarealliance/pages/95/attachments/original/1553489155/seven_deaths_in_darwin_case_studies_unde.pdf?1553489155

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, dozeprin, may limit further increase in dose.”*

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

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

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

Further concerns are raised by the report on case 5. Dr Nitschke reported that *“on this occasion the psychiatrist phoned within 20 min, saying that this case was straightforward”*. This assessment took place on the day on which euthanasia was planned. This case involved an elderly, unmarried man who had migrated from England and had no relatives in Australia. Dr Nitschke recalled *“his sadness over the man’s loneliness and isolation as he administered euthanasia”*. [Dr Nitschke has since revealed in testimony to a Senate committee](https://www.aph.gov.au/~media/wopapub/senate/senate/commttee/S10740_pdf.ashx), that he personally paid for this psychiatric consultation and that it in fact took less than 20 minutes.³⁷

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.

³⁷ https://www.aph.gov.au/~media/wopapub/senate/senate/commttee/S10740_pdf.ashx

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".

Clauses 27 and 38 of the Bill provide that if the assessing practitioner "is unable to decide whether the patient has decision-making capacity in relation to voluntary assisted dying" he or she must refer the patient to "a psychiatrist or another registered health practitioner who has appropriate skills and training to make a decision about the matter".

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.

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.

Clause 16 (2) (a) of the Bill would provide that: "*A person is not eligible for access to voluntary assisted dying merely because the person has a disability*".

The key word in this provision is the word "*merely*" which constrains its operation to very narrow circumstances.

The Bill defines “disability” by reference to its meaning in section 7(1) of the *Disability Inclusion Act* which states that:

disability in relation to a person, includes a long-term physical, psychiatric, intellectual or sensory impairment that, in interaction with various barriers, may hinder the person’s full and effective participation in the community on an equal basis with others.

The Bill not only would allow a person with a disability and a physical disease such as cancer to be prescribed a lethal poison to end his or her life but, would also allow a person’s disability to be considered as a relevant “disease, illness or medical condition” if the person was assessed as “on the balance of probabilities” likely to be dead within six months due to that disability.

Many people living with disability have been given just such a pessimistic prognosis not just once but several times in their lives

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%) .³⁸ **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 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](#):

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<https://assets.nationbuilder.com/australiancarealliance/pages/96/attachments/original/1552018763/Oregon - Twenty one years of assisted suicide.pdf?1552018763>

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.***³⁹

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.

[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

³⁹ <http://www.abc.net.au/rampup/articles/2013/10/18/3872088.htm>

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.⁴⁰

The Bill requires the two assessing medical practitioners to screen for voluntariness and lack of coercion.

However, medical practitioners 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.

Disability activist Marilyn Golden writes :

Research overwhelmingly shows that people with new disabilities frequently go through initial despondency and suicidal feelings, but later adapt well and find great satisfaction in our lives.

However, the adaptation usually takes considerably longer than the mere fifteen-day waiting period [generally] required by assisted suicide proposals.

It is only **eight days** in this Bill.

People with new diagnoses of terminal illness appear to go through similar stages. In that early period before one learns the truth about how good one's quality of life can be, it would be all too easy, if assisted suicide is legal, to make the final choice, one that is irrevocable.

Dr. Richard Radtke, a well-known retired academic oceanographer in Hawaii, provides one such example. Dr. Radtke has had a very disabling form of muscular sclerosis for over 25 years. In the period after his diagnosis, doctors often classified him as terminally ill. He experienced severe depression for two years. Had assisted suicide been legal, he acknowledges that he would have chosen it and died long ago. Today, still with an extremely limiting disability, he has retired from a successful academic career, is a happily married father, remains the president of a charitable foundation, and is grateful for the length and varied experiences of his life.

⁴⁰ https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12211310

By legalising assistance suicide and euthanasia the Bill would pose a direct threat to the lives of people in New South Wales 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.

Supporters of the Bill claim that it has sufficient safeguards to ensure that no person will be at risk of having their lives ended by the administration of a prescribed lethal poison in a sufficient dose to cause death as a result of coercion.

This claim needs to be subjected to the most careful scrutiny.

There are three possible points in the process of the Bill in which coercion – whether subtle or overt – could play a role.

Firstly, in making a request for a prescription of a lethal poison.

Secondly, in the case of administration of the prescribed lethal poison by a medical practitioner, nurse practitioner or registered nurse, at the time of that administration.

And thirdly, in the alternative case of self-administration – or supposed self-administration of the lethal poison.

Taking the third occasion first, it should be noted that once the lethal poison has been prescribed and supplied to a person for the purpose of self-administration by the person at a time of the person’s choosing in order to cause the death of the person, **the Bill lacks any mechanism whatsoever for ensuring that the act of ingesting the poison is done voluntarily and with full knowledge.**

No limit is set by the Bill to the period of time which may elapse between the supply and the ingestion of the lethal poison.

We know from the data from Oregon that this may be months, or even years. The longest duration is 1503 days. That is over four years.

After a lapse of time, even if the assessments of voluntariness and decision-making capacity were always correctly made, there is no way of knowing if they were still valid at the time of ingestion.

Decision-making capacity may have diminished significantly to a point where the person no longer had the capacity to understand the nature of the lethal poison and the consequence of ingesting it.

Without an independent witness present at the time of ingestion there is no way of knowing what subtle pressures have been put on a person to ingest it.

Subtle coercion may not even be motivated by malice. We know from Oregon that for a significant proportion of people one reason for requesting a lethal poison to end their lives is a concern about being a burden on family, friends and caregivers.

In 2019 this was the case for 59.2 % of people in Oregon.

This feeling of being a burden may be increased to the extent it plays on a person's mind by all kinds of subtle messages conveyed by family and caregivers.

"Mum, if it all gets too much don't forget you can always take that medication and die peacefully."

Without an independent witness required to be present at the time of alleged self-administration we simply cannot be sure that the lethal poison was not surreptitiously or even forcibly administered to a person.

There will be no autopsy and no inquiry when a person who has been supplied with a lethal poison under this Bill dies from ingesting it.

The new offences introduced by Clause 123 of the Bill of administering a prescribed lethal substance to another person and by Clause 124 of by dishonesty or pressure or duress inducing another person to ingest the lethal substance will be incapable of discovery and prosecution.

The only other person involved will be dead and there will be no reason to find the death suspicious as the whole purpose of prescribing and supplying the lethal poison in the first place was to achieve the person's death by ingesting it.

Claims that there is no evidence of such abuse in other jurisdictions are therefore of no evidential value.

Elder lawyer, Margaret Dore, cites the case of Tami Sawyer, trustee for Thomas Middleton in Oregon where assisted suicide is legal. Two days after his death by assisted suicide, she sold his home and deposited the proceeds into bank accounts for her own benefit.⁴¹

Having financially defrauded Middleton by subtle persuasion it is more than possible that Tami Sawyer also persuaded or tricked him into taking the poison. But Oregon authorities declined to investigate this possibility.

Turning now to the case of administration of the poison by a medical practitioner, nurse practitioner or registered nurse, it should be noted that the administering practitioner is not necessarily either of the medical practitioners that assessed the person's voluntariness and decision-making capacity at the time the request was made.

The practitioner may have never met the person before they arrive with the prescribed lethal poison ready to administer it.

Nonetheless the practitioner – who may be a registered nurse – is supposed, under Clause 62 of the Bill, to assess the person's decision-making capacity, voluntariness and freedom from pressure or duress immediately before outing the person to death by administration of the lethal poison.

Only the most obvious lack of decision-making capacity or obvious sign of duress would be likely at this point to cause any delay.

The witness required under Clause 63 can't be a family member of the administering practitioner but can be a family member of the person about to be killed.

This witness is required to certify that "the patient's request for access to voluntary assisted dying appeared to be free, voluntary and enduring".

If the witness is truly independent and has never met the person before then this requirement is of little evidential value.

If the witness is a family member or carer they may, of course, be the very person who has been exerting pressure or duress on the person to go ahead with the administration of the lethal poison.

Turning now to the initial assessments of voluntariness and decision-making capacity by the coordinating practitioner and the consulting practitioner the Bill purports to have two safeguards, we do note that these practitioners – and the administering practitioner – are each required to undergo training approved by the Health Secretary under Clause 186 of the

⁴¹ <https://choiceisanillusion.files.wordpress.com/2019/12/amicus-sawyer-arraigned.pdf> noel

Bill which may include training on “identifying and assessing risk factors for pressure or duress”.

There is a similar requirement under Victoria’s *Voluntary Assisted Dying Act 2017*.

The training approved under that Act is done online and takes roughly six hours to complete. Most of the training focuses on administrative processes required under the Act.

The section of it dealing with assessing voluntariness, including the absence of coercion takes just over 5 minutes to complete including a 2 minute 20 second video and slides which take a further 2 minutes 50 seconds to read.

This approved training was prepared by Ben White, a prominent campaigner for assisted suicide and euthanasia laws.

White is 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 2019⁴².

White dissented from several recommendations of his co-authors on measures to assist “clinicians assessing capacity and screening for undue Influence for voluntary assisted dying”.

Not surprisingly none of these measures are reflected in the approved Victorian training.

These include:

- assessing for undiagnosed depression;
- assessing for cognitive impairment associated with Motor Neuron Disease and its effect on decision making capacity; and
- being cautious of any use of supported decision making.

The authors (with the dissent of White) note that “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”.

Clause 6 (1) (f) of the Bill allows for a person to be assessed as having decision-making capacity if the person can “communicate a voluntary assisted dying decision in some way”.

This does not exclude the use of the kind of “supported decision making warned about White’s co-authors but evidently not of sufficient concern to him or the Victorian Secretary of Health and Human Services in approving the mandatory training under its Act.

There is nothing, then, in this Bill to guarantee any better result in the quantity, quality and comprehensiveness of the training to be given to practitioners in assessing decision-making

⁴² <https://onlinelibrary.wiley.com/doi/abs/10.1111/imj.14238>

capacity and voluntariness in making decisions that result in the person's death by lethal poison.

Furthermore, making assisted suicide and euthanasia legal and thereby positively affirming a decision to ask for it as a wise choice in itself creates a framework in which a person with low self-esteem or who is more susceptible to the influence of others may well express a request for assisted suicide or euthanasia that the person would otherwise never have considered.

Nothing in the Bill provides a safeguard against this real possibility.

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

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

Seniors Rights Victoria provides [a useful summary of case law and best practice on undue influence](#) in the financial abuse of elders.⁴³

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 rescission 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.⁴⁴

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)

⁴³ <https://assetsforcare.seniorsrights.org.au/relationship-breaks-down/equity/undue-influence-unconscionable-dealing/>

⁴⁴

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

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.*⁴⁵

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

The data from Oregon shows that in 2018 more one out of two (54.16%) people who died after taking prescribed lethal medication cited concerns about being a “*Burden on family, friends/caregivers*” as a reason for the request.⁴⁶

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.⁴⁷

[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.

⁴⁵ <https://swarb.co.uk/wingrove-v-wingrove-1885/>

⁴⁶ 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>

⁴⁷ https://assets.nationbuilder.com/australiancarealliance/pages/96/attachments/original/1552018763/Oregon_-_Twenty_one_years_of_assisted_suicide.pdf?1552018763

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](#)⁴⁸ shows that in 2017 more than half (56%) of those who died from prescribed lethal drugs cited concerns about being a *“Burden on family, friends/caregivers”* as a reason for the request.

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

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

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

*[“Even if a few grannies get bullied into \[suicide\], isn't that the price worth paying for all the people who could die with dignity?”](#)*⁴⁹

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.

Clauses 27 and 38 of the Bill provide that if the assessing practitioner “is unable to decide whether the patient has is or is not acting voluntarily or whether the patient is or is not acting because of pressure or duress” he or she must refer the patient to “a psychiatrist or another registered health practitioner who has appropriate skills and training to make a decision about the matter”.

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.

⁴⁸ <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf>

⁴⁹ <https://www.medscape.com/viewarticle/879187>

How many wrongful deaths of people in NSW 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 people in New South Wales the Bill would undermine the commitment to **suicide prevention for all** people in New South Wales.

By legalising assisted to suicide and euthanasia for a select group of people in New South Wales, those diagnosed as terminally ill, the Parliament of New South Wales would be affirming that such people 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 people in new South Wales.

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

On Page 15 of the Strategic Framework for Suicide Prevention in NSW 2018–2023 there is a very significant statement:

*The overarching vision of the Framework is that everyone in NSW lives with hope, wellbeing and good health, with fewer lives lost through suicide. The Framework represents the beginning of **our journey towards zero suicides** in NSW.⁵⁰*

Clause 12 (1) of the Bill would provide that:

For the purposes of the law of the State, a person who dies as the result of the administration of a prescribed substance in accordance with this Act does not die by suicide.

This legal fiction of course does change the actual nature of an act of self-administration of a lethal poison for the purpose of ending a person's life.

The Bill provides for a State appointed Board to issue an authorisation to a medical practitioner prescribe an approved S4 or S8 poison in sufficient dose to cause death to be either self-administered by a person or administered to the person by a medical practitioner, nurse practitioner or registered nurse.

In the case of self-administration, this action clearly fits the usual definition and understanding of suicide.

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https://www.nswmentalhealthcommission.com.au/sites/default/files/old/documents/mhc_224947_suicide_prevention_framework_web_fa3.pdf

Factually, there is no difference between a person dying by intentionally ingesting a lethal poison prescribed under the Bill and the same lethal poison obtained illegally. It is a suicide in either case.

One effect of Clause 12 (1) would be that suicides with State approval under the Bill would not be counted in our suicide statistics. We could get closer to our target of zero suicides simply by not counting some those suicides approved by the State.

The National Mental Health and Suicide Prevention Plan was endorsed by the Council of Australian Governments on 4 August 2017 and is in place until 2022.⁵¹

It commits all Australian governments, including NSW to, among other things:

*Aim for **zero suicides within health care settings.***

The Bill would do the exact opposite by **actively facilitating suicide within healthcare settings!**

The National Plan also commits NSW to:

*Reduce the **availability, accessibility and attractiveness of the means to suicide***

Far from contributing to this goal, the Bill would not only specifically **make lethal poisons available and accessible** to people to use to commit suicide with State approval but by its very exist would also **glamorise suicide** and **make suicide seem attractive.**

There is a well-known phenomenon of suicide contagion known as the Werther effect. When Goethe's novel The Sorrows of Young Werther was published in 1774 it led to a wave of suicides by young men.

Guidelines on media reporting on suicides reflect a concern to prevent suicide contagion.

The Bill could have the effect of excluding deaths by ingestion of a lethal poison authorised under its provisions from these guidelines by the legal fiction in Clause 12 (1) that they are not suicides.

This could allow even more glamorised reporting on such deaths – which is already common enough despite the guidelines.

The National Plan also commits NSW to:

*Establish public information campaigns to support the understanding that **suicides are preventable.***

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<http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf>

The Bill is built on an assumption that some suicides are not only unpreventable, but they should be individually authorised and facilitated by the State.

This would undermine significantly the core messages in suicide prevention – that there is always hope, there is always a better way, there is always someone ready to help.

The National Plan also commits NSW to:

*Ensure that “There is **a whole-system approach to suicide prevention, with government, business and the community working together towards the one outcome**”*

The Bill would create a two-system model where suicide is publicly presented (albeit under the euphemism of “voluntary assisted dying by self-administration”) as a wise choice for some people in New South Wales and their suicide is actively facilitated. These people are excluded from all suicide prevention efforts.

This inevitably sends the message that some of us would be better off dead and that suicide can be a peaceful, beautiful thing and a wise choice.

A study of US data comparing States which had legalised assisted suicide with those which have not has shown that legalising assisted suicide is associated with an increase in the overall rate of suicides of 6.5% and of the elderly (65 years and older) by 14.5%.⁵²

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.*⁵³

Like this Bill, 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, 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.

⁵² Jones, David A and D. Paton. “How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?” *Southern Medical Journal* 108 (2015): 599–604.

⁵³ https://www.parliament.vic.gov.au/images/stories/daily-hansard/Assembly_2017/Assembly_Daily_Extract_Thursday_21_September_2017_from_Book_12.pdf

If Ms Hennessy's claim were 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 2017.⁵⁴

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, putting aside the legal fiction declaring a suicide pursuant to a permit issued by the Victorian Secretary of the Department of Health and Human Services not to be suicide, there were an additional 144 suicides in 2020 which were officially recorded by the Voluntary Assisted Dying Review Board as "Confirmed deaths - Medication [that is a lethal poison] 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 in 2020 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.

To pass the Bill would be inconsistent with the shared commitment to reduce suicides to zero under the Strategic Framework for Suicide Prevention in NSW 2018–2023 and with NSW's commitments under the National Mental Health and Suicide Prevention Plan.

⁵⁴ <https://www.coronerscourt.vic.gov.au/sites/default/files/2021-01/Coroners%20Court%20Monthly%20Suicide%20Data%20Report%20-%20December%2020.pdf>

The Strategic Framework explicitly refers to “*elderly people living with chronic physical illness and/or living alone*” as a vulnerable group of people for which a selective suicide prevention intervention is required.

The Bill would fatally undermine such efforts by its suicide facilitation approach.

Suicide is a distressing event that disrupts the lives of families, friends and communities who are bereaved.

Like any other suicide, assisted suicide can profoundly affect surviving family members and friends.

A 2010 study found that about 20% of family members or friends who witnessed an assisted suicide in Switzerland, where assisted suicide is legal, subsequently suffered from full (13%) post-traumatic stress disorder or subthreshold (6.5%) post-traumatic stress disorder.⁵⁵

Proposals to promote assisted suicide for some people runs an unacceptable risk of undermining efforts to prevent suicide for all other members of the community and of increasing the trauma suffered by families, friends and communities due to the suicide of loved ones.

How many wrongful deaths of people in New South Wales by suicide contagion resulting from the legalisation, normalisation (and even glamorisation) of suicide for some people in New South Wales 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.⁵⁶

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.

⁵⁵ <https://linkinghub.elsevier.com/retrieve/pii/S0924933810002683>

⁵⁶ <https://opendata.cbs.nl/statline/#/CBS/en/dataset/81655ENG/table?ts=1525401083207>

The doctor put medication in her coffee to reduce her consciousness deliberately so as to avoid her resisting being given drugs. Nonetheless she physically struggled against the administration of an intravenous lethal injection. **She was physically restrained by family members while the doctor completed the administration of the lethal drugs.**⁵⁷

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 2018.⁵⁸

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.***⁵⁹

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

⁵⁸<https://www.tuchtcollege-gezondheidszorg.nl/binaries/tuchtcolleges-gezondheidszorg/documenten/publicaties/documentatie-procedures/uitspraken/uitspraken-van-persberichten/beslissing-euthanasie-bij-dementie/2018-033bes.pdf>

⁵⁹ <https://www.om.nl/vaste-onderdelen/zoeken/@104443/nursing-home-doctor/>

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 actively resisting being killed was justified based on a valid advanced directive requesting euthanasia.⁶⁰

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 live⁶¹ – 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 6 (2) (b) 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 Clauses 27 and 38 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

⁶⁰ <https://www.theguardian.com/world/2020/apr/21/dutch-court-approves-euthanasia-in-cases-of-advanced-dementia>

⁶¹ 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”.⁶²

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 New South Wales 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?

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:

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

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

*This raises a concern that some deaths may be inhumane.*⁶³

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.⁶⁴

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

Complications occurred in 3% of cases of euthanasia, including spasm or myoclonus (muscular twitching), cyanosis (blue colouring of the skin), nausea or vomiting, tachycardia (rapid heartbeat), excessive production of mucus, hiccups, perspiration, and extreme gasping. In one case the patient's eyes remained open, and in another case, the patient sat up.

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

From 2016 to July 2018 the Board of Procurators General [reported](#) on 11 cases of euthanasia with serious breach of protocols by the doctor, including a failed assisted suicide because the doctor ordered the wrong drug; **seven cases of the muscle relaxant being administered when the person was not in a full coma and therefore potentially causing pain**; and three cases where a first attempt at euthanasia failed and the doctor had to leave the person to get a second batch of lethal drugs.⁶⁵

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

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

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<https://assets.nationbuilder.com/australiancarealliance/pages/139/attachments/original/1551913544/CLINICAL PROBLEMS WITH THE PERFORMANCE OF EUTHANASIA Netherlands.pdf?1551913544>

⁶⁵ <https://www.om.nl/onderwerpen/euthanasie/beslissingen-college/>

lethal dose or had other complications. We simply do not know about the other eight out of nine cases.

Two people in Oregon had seizures in [2017](#) after ingesting the lethal poison.

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

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

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

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

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

At least 18 patients have regurgitated the lethal medication. Seven of these cases occurred in [2016](#) alone.

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

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

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

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

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

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

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

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

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

Relevant to this Bill is the unsurprising fact that many of the lethal poisons used for capital punishment in the United States are the very same lethal poisons used for euthanasia and assisted suicide – including in Victoria.

Although the legal reasons for the State authoring intentionally ending the life of a human being under the death penalty or by euthanasia or assistance to suicide are different, in all these cases **the same physiological process – causing death rapidly and painlessly – is the stated aim.**

It is not surprising then that some of the **same lethal substances** are used.

Sodium pentobarbital has been used for assistance to suicide in the Netherlands, Oregon and Washington (until 2015), and Victoria as well as by several States in the United States in the execution of prisoners.

It seems the most likely Schedule 8 poison to be approved for self-administration in order to cause death under this Bill.

David Waisel, MD, an anaesthesiologist, has testified about the use of this drug in executions:

... as the lethal injection commenced Mr. Blankenship jerked his head toward his left arm and made a startled face while blinking rapidly. He had a "tight" grimacing expression on his face and leaned backward. Shortly thereafter, Mr. Blankenship grimaced, gasped and lurched twice toward his right arm. During the next minute, Mr. Blankenship lifted his head, shuddered and mouthed words. Three (3) minutes after the injection, Mr. Blankenship had his eyes open and made swallowing motions. Four (4) minutes after injection, Mr. Blankenship became motionless. About thirteen (13) minutes after the injection, Mr. Blankenship was declared dead. Again, his eyes were open throughout.

Based on his lurching toward his arms and the lifting of his head and the mouthing of words, I can say with certainty that Mr. Blankenship was inadequately anesthetized and was conscious for approximately the first three minutes of the execution and that he suffered greatly. Mr. Blankenship should not have been conscious or exhibiting these movements, nor should his eyes have been open, after the injection of pentobarbital.

Given prior executions of Brandon Rhode and Emanuel Hammond in September 2010 and January 2011, respectively, during which these inmates reportedly exhibited similar movements and opened their eyes (Rhode's eyes were open throughout the execution

process), Mr. Blankenship's execution further evidences that **during judicial lethal injections in Georgia there is a substantial risk of serious harm such that condemned inmates are significantly likely to face extreme, torturous and needless pain and suffering.**⁶⁶

Another anaesthesiologist, Joel Zivot, MD writes:

In 2014, I watched the lethal injection of Marcus Wellons in a Georgia prison.

I noticed that Wellons's fingers were taped to the stretcher, which made little sense, given his body had already been restrained by heavy straps. I kept asking myself why. I read into the subject and came across a report of the lethal injection execution of another death row inmate, Dennis McGuire, five months earlier. During that 24-minute process at the Ohio jail, McGuire clenched his fists. Perhaps it was a final, futile show of defiance. Perhaps it was an outward display of pain. With his fingers secured, Wellons could not have made any such gesture.

*In 2017, I obtained **a series of autopsies of inmates executed by lethal injection**, which confirmed my worst fears. Wellons's autopsy revealed that his lungs were profoundly congested with fluid, meaning they were around twice the normal weight of healthy lungs. He had suffered what is known as pulmonary oedema, which could only have occurred as he lay dying. **Wellons had drowned in his secretions.** Yet even my medical eye detected no sign of distress at his execution.*

*Wellons was executed with a chemical called pentobarbital, which caused his pulmonary oedema. **If a post-mortem examination were to be performed on a body after assisted suicide, it's very likely that similar pulmonary oedema would be found.***⁶⁷

A 2020 review, published by NPR, of 216 autopsies conducted after execution in US States by lethal injection found signs of pulmonary oedema in 84% of the cases. The findings were similar across the states and, notably, across the different drug protocols used.

Not all states conduct autopsies after lethal injections. Texas, which has performed by far the most lethal injections of any state, has a policy of not conducting autopsies. When asked by NPR about this, a spokesperson for the Texas Department of Criminal Justice said, "We know how they died."⁶⁸

Euthanasia and assistance to suicide laws often include provisions designed to preclude autopsies such as excluding such deaths from being "reportable" to the Coroner and falsifying the death certificate by stating the cause of death as the medical condition for which euthanasia or assistance to suicide had been requested.

The protocol for self-administration of a lethal poison to cause death under Victoria's law, for example, includes an anti-emetic and an anti-anxiety drug to be taken before drinking a

⁶⁶ State of Massachusetts, County of Suffolk., *Affidavit of David B. Waisel, MD*, p. 2-3

⁶⁷ <https://spectator.com.au/2021/09/last-rights/?de0404353fb8&utm>

⁶⁸ <https://www.npr.org/2020/09/21/793177589/gasping-for-air-autopsies-reveal-troubling-effects-of-lethal-injection>

mixture containing 15 g of pentobarbital. However, the person will still be conscious when the pentobarbital is ingested.

Dr Zivot comments that “*without a general anaesthetic, many will be in great discomfort, even if outwardly they don’t appear to be suffering.*”

In her 2015 dissent in *Glossip v Gros*, US Supreme Court Justice Sonya Sotomayor, characterised death by lethal injection as “*the chemical equivalent of being burned at the stake*”.⁶⁹

While the lethal drugs used to execute offenders in the United States are subject to scrutiny in the courts where evidence can be presented that they may cause a painful death, there is no such scrutiny of the drug regimes used for euthanasia and assistance to suicide, which are just as likely to result in such painful and inhuman deaths.

The Bill cannot guarantee that those assisted to commit suicide or euthanased by a medical practitioner, nurse practitioner or registered nurse once authorised by an appointed State official under this Bill will not die a “cruel and inhuman” death

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 31C OF THE *CRIMES ACT 1900*

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 which is similar to section 31C of the NSW *Crimes Act 1900*. 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):

⁶⁹ <https://supreme.justia.com/cases/federal/us/576/14-7955/#tab-opinion-3428063>

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. **This Bill, if passed, would remove from vulnerable people in New South Wales – people like Ms Moran - the protection of Section 31C of the Crimes Act 1900 with its absolute and universal prohibition on aiding, abetting, inciting or counselling another person to commit 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, Washington State and Victoria 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 New South Wales 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 will inevitably lead to the wrongful deaths of some people in New South Wales it ought not be passed.