Assisted suicide: "death expected in not longer than 12 months"

The Andrews government is drafting a Bill to give effect to the recommendations of its Ministerial Advisory Panel on how to "safely" legalise assisted suicide and euthanasia.

Recommendation 2 from the panel's final report includes as part of the eligibility criteria for assisted suicide or euthanasia that a person be "be diagnosed with an incurable disease, illness or medical condition that … is expected to cause death within weeks or months, but not longer than 12 months."

How does prognostication work at 12 months to live? Is it accurate? Is it reliable?

According to primary school arithmetic 12 months is twice as long as the 6 months to live prognosis required in Oregon. **This fact alone makes the claim that the Andrews government Bill will be the most conservative legislation as unreliable as prognoses in such circumstances.**

The Final Report is clear that the prognosis should take into account a decision by the person to forego treatment that may be life prolonging. (page 63)

If this approach is adopted by the Andrews government then, for example, an insulin dependent diabetic, who is not otherwise dying, could qualify for assisted suicide at any stage simply by announcing a decision to cease taking insulin.

The Panel acknowledges that **prognoses may be wrong** but **claims this would be rare.**

> "*The Panel acknowledges that there may be rare instances where a person eligible for voluntary assisted dying does survive beyond the 12-month timeframe. When this occurs the Panel considers that neither the person nor the medical practitioners who assessed the person's eligibility for voluntary assisted dying in good faith and reasonably under the legislation should be penalise*d."

No basis is given for this claim of rarity in faulty prognoses.

PROGNOSIS DIFFICULT TO MAKE ACCURATELY

A prognosis of not being expected to live longer than 12 months **is notoriously difficult to make accurately**.

A study on the accuracy of prognoses in oncology[1] found that "*discrimination between patients who would survive for one year and those who would not was very poor*", described as "*only slightly better than a random guess*".[2]

The *National Consensus Statement: essential elements for safe and high-quality end-of-life care* wisely observes:

> *Predicting prognosis and the timing of dying can be difficult. For some patients, it may be difficult to distinguish clinical deterioration that is reversible from deterioration that is irreversible and part of the normal dying process. In such cases, it may be appropriate to consider a trial of treatment for a defined period to assess reversibility of a patient's deterioration*.[3]

ERRORS IN PROGNOSES ARE COMMON, NOT RARE, THROUGHOUT MEDICAL PRACTICE

Errors in prognosis are not limited to assessment for the purpose of assisted suicide.

One recent study of prognostic accuracy for brain cancer found that "*All physicians had individual patient survival predictions that were incorrect by as much as 12-18 months, and 14 of 18 physicians had individual predictions that were in error by more than 18 months. Of the 2700 predictions, 1226 (45%) were off by more than 6 months and **488 (18%) were off by more than 12 months**.*"

Of particular relevance to the use of a prognosis of expected death within no longer than 12 months to grant access to assisted suicide is the finding that "*In this study all physicians were unable to accurately predict longer-term survivors. **Despite valuable clinical data and predictive scoring techniques, brain and systemic***

management often led to patient survivals well beyond estimated survivals."[4]

A study published in 2000 in the British Medical Journal[5] 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 of not expected to live more than 12 months 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. **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.**

The Panel's **baseless claim** that mistakes in prognosis will be "rare" **is reckless of the lives of those Victorians who may be helped to throw away years of their lives unnecessarily.**

WRONG PROGNOSES COMMON, NOT RARE, IN WASHINGTON AND OREGON

In Washington **14% of the 835 deaths under the assisted suicide law since 2009 (for which the length of time between first request and ingestion of the lethal dose is known), have occurred at 25 weeks or more after a prognosis of no more than 6 months to live.**

In each year since 2010 some deaths have occurred at least 12 months after a prognosis of no more than 6 months to live. In three of these years some deaths have occurred at least 18 months after a prognosis of no more than 6 months to live. And in two of these years, including 2016, some deaths occurred more than 2 years after a prognosis of no more than 6 months to live.

The longest reported survival after a prognosis of no more than 6 months to live under Washington's law is 150 weeks (2 years 10 ½ months)[6].

Under Oregon's law the record is a similar 1009 days (2 years 9 months).

Of course we will never know how long many of those who take the lethal dose within the 6 month period might have lived if they hadn't been given assisted suicide.

Given that the prognostic criterion is proposed to be twice as long as Oregon (12 months rather than 6 months to live) Victoria is likely to involve more cases of people being assisted to suicide who in fact had years to live.

TREATMENT MAY BE EFFECTIVE OR THE DIAGNOSIS MAY BE WRONG

The example of Jeanette Hall, who is still alive today after commencing the process of seeking assisted suicide in Oregon in 2000, illustrates the danger of making assisted suicide available to people when first diagnosed with a terminal illness. Thankfully for Jeanette her doctor refused to collaborate in assisting her suicide and helped her find hope – and effective treatment – instead.[7]

In some cases **the prognosis will be wrong because the diagnosis is wrong**. The person may not even have a terminal illness at all.

For example, it was only after the family of retired Italian magistrate Pietro D'Amico, aged 62, insisted on an autopsy that he was found not to have a terminal illness at all, despite being given such a diagnosis by both Italian and Swiss doctors prior to undergoing assisted suicide in Switzerland.[8]

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*".[9]

Ten per cent of cases in Australia are misdiagnosed according to Peter McClennan, chief executive at Best Doctors.[10]

The critical point to note is that using a 12 months to live criteria for admission to palliative care does not preclude trials of treatment or, of course, unexpected spontaneous recovery. **Using a 12 months to live criteria to prescribe or administer lethal drugs (as soon as 10 days after such a prognosis is first given) excludes these possibilities.**

CONCLUSION

Making assisted suicide available to people diagnosed with a terminal illness and given a prognosis of not expected to live longer than 12 months will **unavoidably result in the deaths of persons who in fact were not terminally ill or who had years to live.** Legalising assisted suicide is too risky.

References:

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