



Hon Nick Goiran MLC

# The safe approach to End of Life Choices: License to Care not Licence to Kill

Minority Report by Hon N.P. Goiran MLC for the Joint Select  
Committee on End of Life Choices submitted under Legislative Assembly  
Standing Order 274

August 2018

Parliament of Western Australia

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**Joint Select Committee  
on End of Life Choices**

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Standing Order 274

**Hon Nick Goiran MLC**

Presented on 23 August 2018



## Foreword

**T**here was only one of the eight members of the Joint Select Committee on End of Life Choices (JSCEOLC) that attended every meeting and every hearing during the course of its year-long inquiry. There is only one of the 95 members of the Parliament of Western Australia that has served on both the JSCEOLC and the Select Committee on Elder Abuse (SCEA). Indeed I am the Chairman of SCEA in addition to being the co-chair of the Parliamentary Friends of Palliative Care. Prior to entering Parliament I was a Partner of a Western Australian law firm and supervised its civil litigation division. That division including a healthy practice in medical negligence law. It is with this background that I present this report.

The JSCEOLC was asked to inquire into and report on the need for laws in Western Australia to allow citizens to make informed decisions regarding their own end of life choices. In particular the Committee was asked to assess current practices (including the role of palliative care), review legislation both inside and outside Western Australia, consider what legislative change may be required (including an examination of any federal laws) and examine the role of Advance Health Directives, Enduring Power of Attorney and Enduring Power of Guardianship laws.

It is readily apparent that the Committee has failed to fulfil the task given to it by the Houses.

During the Legislative Council debate on the motion to agree to the Legislative Assembly's request to form the joint committee, I moved to amend the terms of reference to add that the Committee 'examine the risks of introducing voluntary euthanasia, including the impact on suicide prevention.' My motion was unsuccessful with Hon Sally Talbot MLC assuring the House that 'we will be able to have those discussions within the existing terms of reference' and Hon Alannah MacTiernan MLC saying 'I urge members not to support this amendment.'

The very fact that there was such resistance to what should have been a simple amendment set the scene for what any dispassionate observer could have anticipated for the twelve months that followed.

To ensure that all members of the Parliament of Western Australia and the people of this State have a thorough assessment of the risks of voluntary euthanasia and assisted suicide, I submit this report in accordance with Standing Order 274.

I am convinced that the risks of legalising assisted suicide (however described or defined) are too great as the consequences are final. Indeed I am convinced that assisted suicide is a recipe for elder abuse. The safety of the people of Western Australia ought to be our highest law.

I also have serious concerns for the impact upon our desperate efforts on suicide prevention in Western Australia. Our ongoing suicide rate of around one person per day is tragic and we simply cannot afford the dangerous mixed message that comes with assisted suicide.

In contrast I remain encouraged by and grateful for our health practitioners in palliative care. There is no doubt that they are capable of providing world-class care and comfort for Western Australians suffering from a terminal or chronic illness. They simply need to be given the opportunity to provide it. Consequently, as a compassionate and caring Western Australian community our collective energies should be directed to improving the awareness of, access to, training of and resourcing of our palliative care service providers.

Assisted suicide is bad public policy. Our best public policy option is always care not killing.

A handwritten signature in blue ink, appearing to read 'Nick Goiran', is centered on a light pink rectangular background.

**Hon Nick Goiran MLC**

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## Executive Summary

1. On 23 August 2017, the Parliament of Western Australia established a Joint Select Committee of the Legislative Assembly and Legislative Council to inquire and report on the need for laws in Western Australia to allow citizens to make informed decisions regarding their own end of life choices. In particular the Committee was asked to—
  - (a) *assess the practices currently being utilised within the medical community to assist a person to exercise their preferences for the way they want to manage their end of life when experiencing chronic and/or terminal illnesses, including the role of palliative care;*
  - (b) *review the current framework of legislation, proposed legislation and other relevant reports and materials in other Australian States and Territories and overseas jurisdictions;*
  - (c) *consider what type of legislative change may be required, including an examination of any federal laws that may impact such legislation; and*
  - (d) *examine the role of Advanced Health Directives, Enduring Power of Attorney and Enduring Power of Guardianship laws and the implications for individuals covered by these instruments in any proposed legislation.*
2. Having considered the submissions made to the Committee and the transcripts of those called to give evidence, it is clear that as the law currently stands Western Australians have the following end of life choices available to them:
  - (a) Medical treatment, especially palliative care, and including if necessary palliative sedation therapy;
  - (b) The refusal of medical treatment;
  - (c) The refusal of hydration and nutrition; and
  - (d) Suicide.
3. Advance Health Directives and advanced care planning, including the utilisation of Enduring Powers of Guardianship and Enduring Powers of Attorney, are important means of communicating end of life choices to caregivers, and to ensuring that lawful wishes of the individual are followed.

4. While the final choice, of suicide, is a choice that is available to Western Australians, it is certainly not a choice which the state encourages or promotes. In fact, suicide prevention policies and programs have had long-standing bi-partisan support, as every life in this State matters. Nevertheless, Western Australians have the liberty to choose suicide. Herein lies the important distinction between liberty and license.
5. The choice that is currently not available to Western Australians is that of assisted suicide.<sup>1</sup> This Report concludes that, upon weighing the evidence as a whole, assisted suicide should remain illegal in Western Australia. While it is one thing to have the liberty to suicide, it is quite another for the state to grant medical practitioners a licence to kill patients through assisted suicide.
6. Chapter 1 of this Report considers the end of life choices currently available to Western Australians and how assisted suicide represents a radical departure from these accepted choices.
7. Chapter 2 identifies areas of risk involved in the legalisation of assisted suicide and the failure of ‘safeguards,’ including difficulties with the assessment of capacity and the determination of consent, and issues arising in disability discrimination, suicide prevention, elder abuse and the irreversible consequences of medical error.
8. Chapter 3 considers the experiences of six jurisdictions with legalised assisted suicide, including our own Australian experience in the Northern Territory, as well as experiences from Europe and North America.
9. The submissions and testimonies given to the Joint Select Committee on End of Life Choices cover the field of views on the controversial issue of assisted suicide, with strong opinions and a great depth of feeling held by individuals on both sides of the debate.

*We all will die. How we die—and live at the end of life—is important, with implications for individuals, their families, and society. How we are cared for at the end of life matters.<sup>2</sup>*

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1 The term ‘assisted suicide’ is used in this Report to refer to both ‘voluntary euthanasia’ (where lethal medication is administered by a medical practitioner upon the request of a patient) and ‘physician-assisted suicide’ (where access to lethal medication is provided by a medical practitioner, and self-administered by the patient). ‘Suicide’ is defined as an action taken to intentionally end one’s own life, and despite cultural and historical connotations, the term is neither disparaging nor a judgment. Assisted suicide simply identifies both voluntary euthanasia and physician-assisted suicide, and provides clarity, as other terms such as aid in dying, medical aid in dying, dying with dignity and physician assisted dying could all equally be used to describe palliative care practices.

2 Snyder Sulmasy L and Mueller PS, ‘Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper,’ Professionalism and Human Rights Committee of the American College of Physicians (2017) *Annals of Int Med* 167(8): 576.

## Findings and Recommendations

### Finding 1

Page 12

Specialist palliative care is a relatively new discipline within the medical profession.

### Finding 2

Page 12

Palliative care is poorly understood within the Western Australian community.

### Finding 3

Page 12

The provision of quality palliative care affirms a patient's right to choose their therapy, decline futile treatment, choose their place of dying, receive the best possible relief of symptoms and to refuse to prolong the dying process.

### Finding 4

Page 13

Medical treatment, including palliative care is an end of life choice currently available in Western Australia, however:

- a) Patients with non-malignant diseases are under-represented in palliative care in WA; and
- b) access to good quality palliative care across the State is, in any event, currently highly variable.

### Finding 5

Page 13

Data from the Palliative Care Outcomes Collaboration (PCOC) can be useful in comparing one service provider with another but it is not, nor is it intended to be, an academically rigorous tool to assess palliative care generally.

### Recommendation 1

Page 13

The Minister for Health should consult with the Palliative Care Outcomes Collaboration (PCOC) and service providers to determine a data collection methodology that would set the lowest figures for unmanaged pain symptoms as the aspirational standard for every service provider.

### Recommendation 2

Page 13

The Minister for Health should consult with palliative care service providers to ascertain the current deficit in capacity preventing equitable provision of specialist palliative care across Western Australia.

**Recommendation 3****Page 13**

The Minister for Health should assess the recommendations made by Western Australia's peak body for palliative care and report to Parliament with a plan to:

- a) utilise co-design workshops;
- b) progress the Compassionate Communities model;
- c) introduce shared care models;
- d) increase the capacity of the Silver Chain Hospice Care Service model of care;
- e) build the capacity of existing outpatient clinics to facilitate Advance Care Planning;  
and
- f) increase the availability and flexibility of Telehealth.

**Finding 6****Page 16**

Loss of hunger and thirst occurs frequently as a normal part of the natural dying process.

**Finding 7****Page 17**

Refusal of nutrition and hydration is an end of life choice currently available in Western Australia, however it is significantly distinguishable from assisted suicide as it is based on the right to inviolability and is in any case reversible.

**Finding 8****Page 21**

Refusal of medical treatment is an end of life choice currently available in Western Australia, however it is significantly distinguishable from assisted suicide as it is based on the right to inviolability and is in any case reversible.

**Finding 9****Page 33**

Palliative sedation, when competently administered, is a legal and ethical end of life choice currently available in Western Australia.

**Finding 10****Page 33**

An expanding evidence base has repeatedly confirmed that the appropriate use of sedating or pain-relieving medications does not hasten death.

**Finding 11****Page 33**

Palliative sedation does not hasten death.

**Finding 12****Page 33**

Under-dosing and failure to make a specialist referral are problems that lead to unnecessary suffering and distress for patients and loved ones.

**Finding 13****Page 34**

Under-dosing and failure to make a specialist referral occur because of a lack of medical training and, in some cases, outdated teaching.

**Recommendation 4** **Page 34**  
The Minister for Health should facilitate and monitor an improved communication protocol, and if necessary an improved communication pathway, between medical practitioners and specialist palliative care services.

**Recommendation 5** **Page 34**  
The Minister for Health should develop and roll out a community awareness program about specialist palliative care services.

**Recommendation 6** **Page 34**  
The Minister for Health should consult with palliative care specialists about mechanisms to improve the training and continuous professional education of all health practitioners about specialist palliative care services.

**Finding 14** **Page 36**  
A critical distinction between assisted suicide and the palliative care choices available to Western Australians at end of life is that the current choices available to patients are all reversible.

**Finding 15** **Page 39**  
Calls for the legalisation of assisted suicide are based on social theories of independence and individualism and values of autonomy, self-determination and choice.

**Finding 16** **Page 39**  
There is a distinction between personal autonomy and absolute personal autonomy.

**Finding 17** **Page 54**  
The stakes are high when an individual is given responsibility to distinguish between euthanasia requests that are a mis-expression of an underlying unresolved need, and those that reflect a personal philosophy of choice, despite optimal care.

**Finding 18** **Page 54**  
An assisted suicide regime with an optional referral for psychiatric capacity assessment does not safeguard against the assisted suicide of patients whose capacity is impaired by depression or other mental health considerations, in part because the ability to assess capacity is variable across medical practitioners.

**Finding 19** **Page 55**  
It is inherently complex to determine the influences on drivers to seek end of life in an individual with mental illness.

<b>Finding 20</b>	<b>Page 55</b>
A single psychiatric visit to assess capacity is inadequate to determine whether a psychiatric disorder is impairing the judgment of a patient seeking assisted suicide.	
<b>Finding 21</b>	<b>Page 55</b>
Diagnosing demoralisation is as important as diagnosing depression and other conditions when seeking to alleviate and manage psychological suffering.	
<b>Finding 22</b>	<b>Page 55</b>
Access to consultation-liaison psychiatry in Western Australia is poor.	
<b>Recommendation 7</b>	<b>Page 55</b>
The Minister for Health should develop a plan to increase the number of consultation-liaison psychiatrists in Western Australia.	
<b>Finding 23</b>	<b>Page 55</b>
The introduction of a legalised assisted suicide regime in Western Australia would present a grave risk to patients, especially those in an advanced stage of their illness whose wish for hastened death has not been assessed and addressed by a specialised consultation-liaison psychiatrist.	
<b>Finding 24</b>	<b>Page 58</b>
Mandatory psychiatric assessment cannot eliminate error in capacity assessments.	
<b>Finding 25</b>	<b>Page 58</b>
No assisted suicide regime, even with mandatory psychiatric assessment, can safeguard against the assisted suicide of a person suffering from a treatable mental illness.	
<b>Finding 26</b>	<b>Page 61</b>
A valid consent to medical treatment is dependent on the:	
a) capacity of the patient;	
b) patient’s knowledge of the treatment options; and	
c) the voluntariness of the decision.	
<b>Finding 27</b>	<b>Page 65</b>
Countertransference and/or undue influence from a medical practitioner would be two dangerous risks in any assisted suicide regime.	
<b>Finding 28</b>	<b>Page 73</b>
Elder abuse is a real and burgeoning problem in Western Australia.	



<b>Finding 29</b>	<b>Page 73</b>
The capacity of medical practitioners to identify elder abuse in their patients is incredibly variable in Western Australia.	
<b>Finding 30</b>	<b>Page 73</b>
Redress can be difficult in some elder abuse cases when the best witness lacks capacity to give evidence.	
<b>Finding 31</b>	<b>Page 73</b>
Redress in any assisted suicide case is an impossibility.	
<b>Finding 32</b>	<b>Page 73</b>
The presence of undue influence can be difficult to identify and is easily missed.	
<b>Finding 33</b>	<b>Page 73</b>
The introduction of a legalised assisted suicide regime in Western Australia would be a recipe for elder abuse.	
<b>Recommendation 8</b>	<b>Page 73</b>
The Minister for Seniors and Ageing should develop and roll out a comprehensive plan to tackle elder abuse in Western Australia.	
<b>Finding 34</b>	<b>Page 82</b>
Assisted suicide laws are, at their core, about disability.	
<b>Finding 35</b>	<b>Page 82</b>
Assisted suicide laws enshrine a negative message about living with a disability.	
<b>Finding 36</b>	<b>Page 82</b>
There can be no protection or safeguard in any law that begins with the implicit proposition that it is better for some people to be dead than disabled.	
<b>Finding 37</b>	<b>Page 82</b>
People with disabilities experience discrimination and inequity of access to health care in Western Australia.	
<b>Recommendation 9</b>	<b>Page 82</b>
The Minister for Disability Services should develop a plan, in consultation with people with disabilities, carers, the Minister for Health and health practitioners, to deliver equitable access to health care in Western Australia.	

**Finding 38****Page 83**

An assisted suicide regime threatens to create a two-tiered system where individuals without a disability who express that they wish to end their life are referred to suicide prevention services, while individuals with disabilities who express that they wish to end their life are referred for lethal prescriptions.

**Finding 39****Page 97**

An assisted suicide regime in Western Australia would send a message that suicide is a legitimate solution in certain circumstances.

**Finding 40****Page 98**

Some proponents of assisted suicide endeavour to resolve the dilemma of inconsistency on suicide prevention by banishing the word 'suicide' from the debate in favour of the phrase 'assisted dying.'

**Finding 41****Page 98**

The highly publicised case of Dr David Goodall involved circumstances of overt ageism, troubling signs of suicide celebration and a seeming absence of any suicide prevention measures at work.

**Finding 42****Page 98**

The suicide rates in people aged 80 and above is a particular concern in Western Australia.

**Finding 43****Page 98**

The reason for older age suicide is complex and usually multifactorial, and should not be confused with the misconception that such suicides are driven by suffering associated with chronic, debilitating or terminal illness.

**Recommendation 10****Page 98**

The Minister for Mental Health, in consultation with the Minister for Seniors and Ageing, should expand suicide prevention programs to further target older Western Australians.

**Recommendation 11****Page 98**

The Minister for Mental Health should direct the Mental Health Commission to conduct an urgent review, outside and separate to any other general review processes underway, into the effectiveness of Western Australia's current suicide prevention strategies and programs in light of the Dr David Goodall case.

**Finding 44****Page 98**

Coronial data identified the suicide of 199 Western Australians with a terminal or debilitating condition between 2012 and 2017. Examination of the data reveals that 42 may be capable of being classified as suffering from a terminal condition and 157 with a debilitating one. Of the 42 cases, 27 can be identified as being in the advanced or terminal stage of illness. Of the 157 cases, 99 evidenced some level of mental ill-health.

**Finding 45****Page 98**

A close and proper examination of the coronial data of suicides between 2012 and 2017 does not support the assertion that individuals suicide because palliative care is not an adequate treatment option, but rather confirms the multifactorial nature of suicide.

**Finding 46****Page 108**

Governing medical bodies both inside and outside Western Australia discourage medical practitioners from participating in assisted suicide, even if the local law allows it or decriminalises it.

**Finding 47****Page 108**

The licencing of medical practitioners to assist in the suicide of their patients alters the role of the medical profession.

**Finding 48****Page 108**

There are multiple conflicts of interest for a medical practitioner assisting in the suicide of their patient.

**Finding 49****Page 109**

An assisted suicide regime would improperly absolve a medical practitioner of responsibility for giving a lethal injection to their patient or for giving their patients a prescription to poison themselves.

**Finding 50****Page 115**

A safeguard in an assisted suicide regime that involves a medical practitioner is only as safe as the practitioner is competent.

**Finding 51****Page 115**

A safeguard in an assisted suicide regime that involves a medical practitioner is unable to protect against unconscious incompetence.

**Finding 52****Page 116**

A safeguard in an assisted suicide regime that involves a medical practitioner is unable to protect against mistake, error or negligence.

- Finding 53** **Page 116**  
Legalisation of assisted suicide will attract participation by medical practitioners who are also advocates of the practice.
- Finding 54** **Page 116**  
Even if the risk of doctor bias toward assisted suicide is the same as doctor bias in general, the consequences are not comparable.
- Finding 55** **Page 116**  
Doctor shopping is a clear danger of an assisted suicide regime, with no solution apparent.
- Finding 56** **Page 126**  
There is a large body of evidence of medical error in prognosis.
- Finding 57** **Page 126**  
Any safeguard in an assisted suicide regime is rendered useless in the event of medical error in prognosis.
- Finding 58** **Page 126**  
There is a large body of evidence of medical error in diagnosis.
- Finding 59** **Page 126**  
Any safeguard in an assisted suicide regime is rendered useless in the event of medical error in diagnosis.
- Finding 60** **Page 128**  
Although a patient, or their substitute decision maker, is entitled to refuse lawful treatment, there is no entitlement at law by a patient to demand treatment.
- Finding 61** **Page 128**  
The proposition that a patient has a right to received assistance to suicide is wrong both at law and in medical ethics.
- Finding 62** **Page 132**  
The emotional and psychological effects on medical practitioners participating in assisted suicide are substantial and consequential.
- Finding 63** **Page 132**  
The desensitisation of medical practitioners by participation in assisted suicide exacerbate the risk that already exists due to doctor bias.

**Finding 64****Page 132**

The rate of psychological distress and attempted suicide by medical practitioners is high.

**Recommendation 12****Page 132**

The Minister for Mental Health should direct the Mental Health Commission to develop, in consultation with medical practitioners and the Department of Health, a comprehensive mental health strategy for prevention, early intervention and crisis intervention for the whole of the medical profession.

**Finding 65****Page 140**

Evidence of complication rates of physician assisted suicides in Oregon until 2010 are troubling. Complication rates after 2010 artificially declined as from this time reports of complications were only recorded if a physician was present at the time of administration.

**Finding 66****Page 140**

Evidence of complication rates in Washington are equally troubling with multiple instances of regurgitation, one-third of patients taking in excess of one and a half hours to die, at least one patient suffering a seizure and another taking 30 hours to die.

**Finding 67****Page 141**

Decades of experience in administering capital punishment, euthanasia and assisted suicide indicate complications are inevitable and this alone ought to militate against legalisation in Western Australia.

**Finding 68****Page 147**

The onus is on those advocating for a change in the law to establish that such a profound change will be safe for the whole community. Anything less results in nothing more than the trading of lives.

**Finding 69****Page 147**

The best possible outcome in an assisted suicide regime is that a person who was dying, dies sooner than they would have. The worst possible outcome in an assisted suicide regime is a wrongful death.

**Finding 70****Page 162**

When assisted suicide was legal in the Northern Territory one patient, diagnosed with mycosis fungoides and receiving treatment for depression, was euthanised on the certification of an orthopaedic surgeon with no expertise in the condition, notwithstanding that a dermatologist and a local oncologist had assessed that the patient was not terminally ill.

**Finding 71****Page 163**

When assisted suicide was legal in the Northern Territory one patient was euthanised even though he was jaundiced and suffering from a bowel obstruction and not advised of the palliative care and medical treatment available. The psychiatric certification in that case consisted of a 20-minute consultation paid for by Dr Philip Nitschke on the day the assisted suicide was scheduled.

**Finding 72****Page 163**

Doctor shopping took place when assisted suicide was legal in the Northern Territory.

**Finding 73****Page 163**

When assisted suicide was legal in the Northern Territory one patient, who had received counselling and anti-depressant medication for several years, was euthanised after a psychiatrist from another State certified that no treatable clinical depression was present, notwithstanding that 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 assisted suicide.

**Finding 74****Page 163**

The clinical experience observed during the period when assisted suicide was legal in the Northern Territory demonstrates the inadequacies of safeguards and this experience alone ought to militate against legalisation in Western Australia.

**Recommendation 13****Page 163**

The Government and the Parliament of Western Australia should rule out introducing any assisted suicide regime based on the Northern Territory experience.

**Finding 75****Page 173**

In 1973, Dutch courts interpreted a defence of necessity to permit a doctor to avoid liability for euthanasia and assisted suicide by pointing to his or her duty to reduce suffering or to respect the autonomy of the patient.

**Finding 76****Page 173**

After 1973, Dutch courts elaborated on their interpretation of a doctor's defence of necessity, incrementally increasing the scope of practice of euthanasia in the Netherlands, including for psychiatric illness, albeit restricted to adults only.

**Finding 77****Page 173**

In 2001 the Netherlands passed statutory law to fit the existing practice of euthanasia but extended it to allow for children as young as 12 to be euthanised subject to parental consent (even in the presence of disagreement between parents).

- Finding 78** **Page 173**  
In 2005, the Netherlands endorsed the Groningen Protocol to further extend the practice of euthanasia to younger children, including newborns.
- Finding 79** **Page 173**  
Consistent with the Northern Territory experience, assisted suicide in the Netherlands takes place notwithstanding disagreement amongst physicians about patient eligibility.
- Finding 80** **Page 173**  
Doctor shopping in the Netherlands has now become commercialised by the emergence of at least one private organisation who will provide assisted suicide to patients whose own physician has declined.
- Finding 81** **Page 173**  
The latest frontier in the Netherlands is a debate on whether assisted suicide should be extended to those who are ‘tired of life.’
- Finding 82** **Page 173**  
In the Netherlands in 2011, the Regional Euthanasia Review Committee found that the attending physician failed to accurately diagnose the patient’s back pain.
- Finding 83** **Page 173**  
In the Netherlands in 2012, the Regional Euthanasia Review Committee found that two cases of patients with dementia were not handled with due care.
- Finding 84** **Page 174**  
In the Netherlands in 2013, an assisted suicide took place of a patient who had a broken thigh following an attempted suicide.
- Finding 85** **Page 174**  
In the Netherlands in 2014, the assisted suicide of a woman over 80 years of age with chronic depression took place on the certification of a physician who was not a psychiatrist, who did not consult psychiatrists and was unaware of the Dutch Psychiatric Association Guidelines.
- Finding 86** **Page 174**  
In the Netherlands in 2015, the Regional Euthanasia Review Committee found a lack of due care on a euthanasia carried out on a woman with a history of stomach pains from an undiagnosed cause.

**Finding 87****Page 174**

In the Netherlands in March 2018, criminal investigations were confirmed as having been launched into four cases of euthanasia in 2017.

**Finding 88****Page 174**

The defence of necessity also exists in Western Australian common law. It has, however, been expressly excluded as a defence to both homicide and euthanasia.

**Finding 89****Page 174**

The experience observed of assisted suicide in the Netherlands demonstrates an incremental extension in the practice of assisted suicide, the commercialisation of doctor shopping, and the reality that no redress is available when safeguards inevitably fail.

**Recommendation 14****Page 174**

The Government and the Parliament of Western Australia should rule out introducing any assisted suicide regime based on the Netherlands experience.

**Finding 90****Page 180**

Similar to the Netherlands, Belgium allows assisted suicide for patients diagnosed with a mental illness.

**Finding 91****Page 180**

The abuse of practice in Belgium, including approval on the grounds of suicidal ideation, has led to at least 252 Belgian clinicians calling for a review of the law on assisted suicide.

**Finding 92****Page 181**

In Belgium in 2012, a 44-year-old woman was euthanised by her psychiatrist on the grounds of unbearable psychological suffering notwithstanding her history of sexual abuse by a psychiatrist under the guise of therapy.

**Finding 93****Page 181**

In Belgium in 2013, an adult male who had undergone gender reassignment surgery was euthanised on the grounds of unhappiness, notwithstanding that the patient's family had rejected him from birth due to his female biology.

**Finding 94****Page 181**

Belgian physicians the subject of a peer-reviewed study in 2010 confirmed the use of life-ending drugs without an explicit request from the patient, including because they considered discussion would have been harmful or because they considered the decision was in the patient's best interest.



**Finding 95****Page 181**

The experience observed of assisted suicide in Belgium demonstrates an extension in the law and practice of assisted suicide, the inadequacies of safeguards and the undeniable reality that no redress is available to patients after the event.

**Recommendation 15****Page 181**

The Government and the Parliament of Western Australia should rule out introducing any assisted suicide regime based on the Belgian experience.

**Finding 96****Page 188**

Assisted suicide in Switzerland is based on a penal code that allows, by omission, for a person to assist another to suicide.

**Finding 97****Page 188**

At least four assisted suicides in Switzerland have occurred while practitioners experimented with the use of helium, which results in agitated muscles, eyes opening and closing, and arms and legs twitching without coordination.

**Finding 98****Page 188**

In Switzerland in April 2013, a retired Italian magistrate, aged 62, was assisted to suicide on the basis of a terminal illness diagnosed by Italian and Swiss doctors only for an autopsy to find no terminal illness.

**Finding 99****Page 188**

The experience observed of assisted suicide in Switzerland underscores the inherent difficulty in testing the integrity of safeguards after the event whilst re-confirming the impossibility for redress by the victim after the event.

**Recommendation 16****Page 188**

The Government and the Parliament of Western Australia should reject the advice of Dr Nitschke and rule out introducing an assisted suicide regime based on the Swiss model.

**Finding 100****Page 195**

In 2016 the Canadian Parliament enacted an assisted suicide law for a person facing a reasonably foreseeable natural death, only to have the Supreme Court of Ontario interpret the provision so as to extend its application to a person not terminally ill but who has an irreversible deteriorating chronic illness.

**Finding 101****Page 196**

In late 2016 the Canadian Government commissioned reviews to explore a further extension of assisted suicide laws to minors, to those making an advance request and to those where mental illness is the sole underlying condition.

**Finding 102****Page 196**

In February 2018 a Canadian Court has ruled that physicians with a conscientious objection to assisted suicide are nevertheless obliged to refer their patient to a practitioner who will execute the assisted suicide.

**Finding 103****Page 196**

In the first nine months following the passage of an assisted suicide law in Quebec it was found the law had been breached in 21 cases. In the second year of operation, breaches occurred in 31 cases.

**Finding 104****Page 196**

In the short experience of the Canadian law on assisted suicide there has already been at least one case of a doctor assisting a suicide by lethal injection notwithstanding that the patient did not suffer a serious incurable illness.

**Recommendation 17****Page 196**

The Government and the Parliament of Western Australia should reject the advice of Dying with Dignity WA (formerly known as the Western Australian Voluntary Euthanasia Society) and rule out introducing an assisted suicide regime based on the Canadian model.

**Finding 105****Page 205**

The law on assisted suicide in Oregon has been in force for 20 years and requires a prognosis of less than six months to live.

**Finding 106****Page 205**

The data from the Oregon Public Health Division between 1998 and 2015 indicates that the longest recorded duration between initial request for assisted suicide and ingestion of the prescribed lethal drug was 1009 days.

**Finding 107****Page 205**

The data from the Oregon Public Health Division in 2015 indicates that the longest recorded duration between initial request for assisted suicide and ingestion of the prescribed lethal drug was 517 days.

**Finding 108****Page 205**

The data from the Oregon Public Health Division between 1998 and 2015 indicates that in 4 of the 17 years there was at least one case where the duration between initial request for assisted suicide and ingestion of the prescribed lethal drug was more than two years.

**Finding 109****Page 205**

The experience in Oregon demonstrates the inadequacies of safeguards due to consistent medical error in prognosis.

**Finding 110****Page 205**

In Oregon a 76-year-old cancer patient was assisted to suicide by his cancer specialist notwithstanding the presence of depression and the non-concurrence of the original doctor who referred the patient to the specialist for treatment.

**Finding 111****Page 205**

In Oregon an octogenarian cancer patient was assisted to suicide notwithstanding that two doctors, including her own physician, were concerned about the presence of depression and refused to prescribe the lethal drug requested.

**Finding 112****Page 205**

The experience in Oregon demonstrates the ease with which the prolific practice of doctor shopping pierces the veil of even well intentioned safeguards.

**Finding 113****Page 206**

The data from the Oregon Public Health Division for 2016 indicates that in 79.4 per cent of assisted suicides no physician or healthcare provider was known to be present at the time of ingestion of the prescribed lethal drug.

**Finding 114****Page 206**

The rate of suicide among Oregonians has been increasing even when assisted suicides are excluded from the data set.

**Finding 115****Page 206**

The inherent difficulty in prosecuting after the event is underscored by at least five assisted suicides in Oregon that occurred by illegal overdoses administered by a nurse.

**Finding 116****Page 206**

The experience observed in Oregon should be reason alone to militate against legalisation in Western Australia.

**Recommendation 18** **Page 206**  
The Government and the Parliament of Western Australia should rule out introducing any assisted suicide regime based on the Oregonian experience.

**Finding 117** **Page 215**  
None of the jurisdictions where assisted suicide has been legalised have yet developed a system that gathers reliable data on all requests and instead rely on the self-reporting of doctors notwithstanding the inherent conflict of interest present.

**Finding 118** **Page 215**  
Western Australia’s Director of Public Prosecutions has no capacity to compel evidence from the sole surviving witness in an assisted suicide.

**Finding 119** **Page 216**  
There is no capacity for a victim of a wrongful assisted suicide to seek redress.

**Finding 120** **Page 216**  
Capital punishment was abolished in Western Australia, notwithstanding the extensive safeguards in the State’s criminal justice system, due to the risk that an innocent person may be executed.

**Finding 121** **Page 216**  
Authentic oversight of an assisted suicide regime is made difficult by a reliance on self-reporting and is made impossible by the unavailability of the best witness.

**Recommendation 19** **Page 216**  
The Government and the Parliament of Western Australia should rule out introducing any assisted suicide regime due to the known unresolved issues with reporting, investigation, prosecution and redress.

**Finding 122** **Page 245**  
A 2013 review by the High Court of Ireland of the available evidence from jurisdictions with assisted suicide produced the conclusions that the examples of abuse are deeply disturbing, that certain groups are vulnerable to abuse, and that the number of suicides remain strikingly high.

**Finding 123** **Page 245**  
Unlike other jurisdictions, there is yet to be any lived experience with the Victorian model of assisted suicide.

**Finding 124****Page 245**

The Victorian model of assisted suicide has been heavily criticised by proponents of assisted suicide, with calls to extend the scope already made before the law has even come into force.

**Finding 125****Page 245**

It is a political inevitability that once lawmakers introduce a right for one group of people that others will soon demand the extension of that right to them on the ground of equality.

**Finding 126****Page 245**

Any restriction on eligibility within an assisted suicide regime is both arbitrary and discriminatory.

**Finding 127****Page 245**

It is at best premature to base any assisted suicide regime on the untested Victorian model.

**Recommendation 20****Page 245**

The Government and the Parliament of Western Australia should rule out introducing an assisted suicide regime based on the untested Victorian model.



# Chapter 1

## Current End of Life Choices in Western Australia

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I have serious concerns about a community where we make arbitrary decisions about whose life is valuable enough to continue and whose should be ended under the law. A society should aspire to look after people who are struggling and to make sure that their lives are worth living. We should aspire to even better end-of-life care. We should aspire to better palliative care.

Dr Michael Gannon MBBS MRCPI FRANZCOG,  
President of the Australian Medical Association (as he was at that time), May 2018

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### Palliative Care

#### What is Palliative Care?

- 1.1. Palliative care as a discipline is poorly understood by the community as well as by health care providers. Palliative Care WA identify that there is little information publicly available about palliative care, that health carers are not actively referring and display a reticence to discuss the issue of dying, and that a misconception exists that palliative care is just for the final days or weeks of life, or is only available for people with cancer.<sup>3</sup>
- 1.2. To palliate means to 'make (a disease or its symptoms) less severe without removing the cause.'<sup>4</sup> Palliative care is an approach that improves the quality of life of individuals, including their family/carer, facing problems associated with a life-threatening illness or condition, 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.<sup>5</sup> It is well understood in palliative care practice that 'suffering is an affliction of the person, not the body.'<sup>6</sup>
- 1.3. Palliative care serves to maximise the quality of life of the individual and addresses their physical, social, financial, emotional and spiritual distress. Such distress not only

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3 Palliative Care WA, JSCEOLC Response to Questions on Notice, 19 December 2017 at 3.

4 WA Cancer and Palliative Care Network, Department of Health (2018) *WA End-of-Life and Palliative Care Strategy 2018-2028* at 3.

5 World Health Organisation (2016) 'WHO Definition of Palliative Care'  
<<http://www.who.int/cancer/palliative/definition/en/>>

6 Cassel E (1999) 'Diagnosing suffering: a perspective' *Ann Intern Med* 131(7) at 531-4.

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influences the experience of having a life-limiting illness, but also influences treatment outcomes.<sup>7</sup>

- 1.4. Palliative care affirms life and regards dying as a normal process, and intends neither to hasten nor to postpone death.<sup>8</sup>
- 1.5. Palliative care is broadly divided into specialist palliative care and non-specialist palliative care. Specialist palliative care services are services provided by health professional teams who have recognised qualifications or training in palliative care and who provide direct care to patients with complex palliative care needs or provide consultation services to support, advise and educate other healthcare teams who are providing end-of-life care. Non-specialist palliative care may be provided by a person's primary care team—for example, by their general practitioner (GP) or other doctor, such as a geriatrician or oncologist, and other healthcare professionals such as nurses, occupational therapists and social workers.<sup>9</sup>
- 1.6. Palliative care is more than relief of pain and includes non-physical care including the attendance of spiritual, psychological and relational needs. Palliative care practitioners seek to determine which aspects of an individual's experience cause distress or suffering and they address each of these in turn, including fear, a sense of hopelessness, loneliness and isolation.<sup>10</sup> This focus on the holistic needs of the patient also recognises that palliative care must be delivered not only to the patient, but also to their family or carer.<sup>11</sup>
- 1.7. Good palliative care helps patients and their families avoid both overtreatment and neglect of treatment. It enhances patient autonomy and decision-making capacity by improving symptom control and empowering patients to participate in their care. It affirms the patient's right to choose their therapy, decline futile treatment, choose their place of dying, receive the best possible relief of symptoms and to refuse to prolong the dying process.<sup>12</sup>

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7 Kamal, LeBlanc and Meier (2016) 'Better palliative care for all: Improving the lived experience with cancer' *The Journal of the American Medical Association* 316(1) at 29-30.

<<https://www.ncbi.nlm.nih.gov/pubmed/27244674>> cited in WA Cancer and Palliative Care Network, Department of Health (2018) *WA End-of-Life and PC Strategy 2018-2028* at 3.

8 Palliative Care Nurses Australia, Jane Phillips, President, JSCEOLC Response to Questions on Notice, 29 January 2018 at 7.

9 Ms Glogowski, Executive Officer, Palliative Care WA, JSCEOLC Transcript, 14 December 2017, Session 4 at 1-2.

10 Ms Re, Chief Executive Officer, IdentityWA, JSCEOLC Response to Questions on Notice, 10 April 2018 at 2.

11 Ms Glogowski, Executive Officer, Palliative Care WA, JSCEOLC Transcript, 14 December 2017, Session 4 at 1-2.

12 Prof Bridge (2017) 'Palliative care, euthanasia and physician assisted suicide' *Med J of Aus InSight*, 20 March 2017, quoted in Rev Dr Parkinson, Director, LJ Goody Bioethics Centre, JSCEOLC Submission 53 at 9.



- 1.8. Patients who access palliative care are consistently shown to have fewer hospitalisations, shorter stays in hospital, reduced use of intensive care facilities and fewer admissions to emergency departments, amounting to significant cost savings in the health system. There is also increasing evidence that appropriate end-of-life and palliative care reduces unnecessary testing and futile treatments.<sup>13</sup>
- 1.9. Palliative care respects informed patient choice including the refusal of any or all medical treatments. This is achieved by emphasising communication with the patient and providing the best quality holistic care.<sup>14</sup> Consent is obtained before making treatment changes, and treatment recommendations are generally made by a multidisciplinary team, rather than by an individual doctor. It is this focus on constant communication and multidisciplinary decision making that is absent from many other parts of the health care system. The focus on communication, and respect for the patient's values and wishes, assists in maintaining trust between health professionals and patients and the relationship between specialist palliative care professionals and patients is, from experience, far less likely to be compromised than in the health care system generally.<sup>15</sup>
- 1.10. Palliative care is a relatively new concept in medical care, and in only a few decades significant improvements in palliative care have been made, and new gains continue to be made, such that Associate Professor Ian Haines, MBBS, medical oncologist and palliative medicine specialist, writes:

*As an oncologist with 35 years' full-time experience, I have seen palliative care reach the point where the terminally ill can die with equal or more dignity than euthanasia will provide. It is now very effective and increasingly available for two of the three possible ways of dying, outside of sudden unexpected death, which are advanced cancer and chronic relapsing and remitting organ-specific disease such as heart or lung failure. Palliative care is also available for people with chronic progressive cognitive diseases such as dementia. This is the fourth way of dying and perhaps the most feared of all. Like Andrew Denton and others who have observed unbearable suffering in loved ones and the terrible failures of modern medicine in the past, I had once believed that euthanasia was the only humane solution. I no longer believe that.*<sup>16</sup>

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13 Mrs Greenwood, Chief Executive, Catholic Health Australia, JSCEOLC Transcript, 28 February 2018, Session 1 at 2, citing Palliative Care Australia data.

14 Palliative Care WA, JSCEOLC Response to Questions on Notice, 19 December 2017 at 5.

15 Ibid.

16 Ian Haines, 'I believed that euthanasia was the only humane solution. I no longer believe that' *The Age*, 20 Nov 2016, quoted by Mr Richard Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 3.

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- 1.11. The WA Department of Health and the Australian Medical Association (WA) assert that palliative care is a human right and is fundamental to improving the quality of life, wellbeing and dignity of all individuals.<sup>17</sup>

### **Palliative care provision in Western Australia**

- 1.12. Palliative care in Western Australia is provided in a number of settings. Specialist palliative care teams operate in some hospitals, providing consultancy and direct care for patients in the hospital setting. There are also designated palliative care units in metropolitan Perth, including Bethesda Hospital, St John of God Murdoch hospice, and the Kalamunda Hospital Anderton Ward. Community services, including Silver Chain, and the Metropolitan Palliative Care Consultancy Service also operate. The Silver Chain program is a successful program unique to Western Australia, with evidence that 80 to 85 per cent of people in their care who wish to die at home are able to achieve that goal. These statistics compare very favourably with national figures, where the wish to die at home is far less often achieved.<sup>18</sup>
- 1.13. Rural service provision is supported by telehealth and telephone advisory services.<sup>19</sup> Mr Brett Hayes, of the WA Country Health Service and 2018 Nurse of the Year, established a pilot program to put telehealth in the home of palliative care patients to provide access to specialist nursing services and access to GP and specialist services when needed. This has been a very successful model of care in the Wheatbelt and is being introduced in the South West and Great Southern regions.<sup>20</sup>
- 1.14. Education initiatives for metropolitan and rural health workers also exist, including the Palliative and Supportive Care Education service (PaSCE), based in the Cancer Council of WA (but providing palliative care education across all diagnoses), the Program of Experience in the Palliative Approach (PEPA) and the Talking about End of Life training program. The Goals of Patient Care program aims to improve decision-making and support shared decision-making for patients in a hospital setting and help to determine the goals of each individual patient.<sup>21</sup> The Metropolitan Palliative Care Consultancy Service (MPaCCS) provides a specialist palliative care approach to residents of aged-care

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17 See WA Cancer and Palliative Care Network, Department of Health (2018) *WA End-of-Life and PC Strategy 2018-2028*, at iii, referencing World Health Organisation (2014) 'Strengthening of palliative care as a component of comprehensive care throughout the course of life,' Geneva, Switzerland at 5; and Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 18 May 2018, Session 1 at 14.

18 Prof Evans, Chief Advisor, Public Policy, Silver Chain Group, JSCEOLC Transcript, 15 December 2017, Session 3 at 1.

19 Ms Bolleter, Program Manager, Palliative Care, Department of Health, JSCEOLC Transcript, 13 December 2017, Session 1 at 2-3.

20 Mrs Baxter, Executive Director, Nursing and Midwifery, WA Country Health Service, Department of Health, JSCEOLC Transcript, 18 May 2018, Session 2 at 13.

21 Ms Bolleter, Program Manager, Palliative Care, Department of Health, JSCEOLC Transcript, 13 December 2017, Session 1 at 3-4.

facilities to build the capacity of those facilities to manage the needs of those in their care to reduce hospitalisations.<sup>22</sup>

- 1.15. However, access to good quality palliative care across Western Australia is currently highly variable, with data indicating that 60 per cent of WA residents who would benefit from access to palliative care are unable to do so.<sup>23</sup> Additionally, current palliative care services have insufficient capacity to meet growing demand.<sup>24</sup> After a declining death rate for several decades (as a result of public health initiatives and medical advances), the total number of deaths in Australia is now expected to grow at increasing rates year-on-year as a result of growing and ageing populations and the impact of chronic disease.<sup>25</sup> This increasing demand for specialist palliative care and end-of-life support in Western Australia presents an urgent problem for access to good quality palliative care in this state.
- 1.16. The Committee received much evidence that Western Australians living in rural and remote areas, Aboriginal and Torres Strait Islanders and persons from culturally and linguistically diverse (CALD) backgrounds experience inequitable provision of specialist palliative care services.<sup>26</sup>
- 1.17. There is also evidence that patients with non-malignant diseases are under-represented in palliative care in Western Australia. In a 2006 study, more people with cancer (64 per cent) had received palliative care in comparison with other illnesses such as heart disease, dementia and organ failure (4-10 per cent). These non-malignant diseases are still under-represented in palliative care ten years on from this study.<sup>27</sup>

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22 Mr Hays, Acting Manager, Purchasing and Contracting, Department of Health, JSCEOLC Transcript, 13 December 2017, Session 1 at 4.

23 Palliative Care WA, JSCEOLC Response to Questions on Notice, 19 December 2017 at 3

24 Ibid.

25 Australian Bureau of Statistics (2013) 3222.0 *Population Projections, Australia, 2012 (Base) to 2101*, quoted in Yasmin Naglazas, Bethesda Health Care, Further information to the JSCEOLC following visit to Bethesda Health Care facility, 18 April 2018, at 1.

26 For example, see AMA(WA), JSCEOLC Submission 685 at 3; WA Cancer and Palliative Care Network, Department of Health (2018) *WA End-of-Life and Palliative Care Strategy 2018-2028*, at 7, referencing Department of Health (2016) *Palliative Care Models of Care Review 2015-16: Outcomes Report*; Mrs Buchanan, Committee Member, Palliative Care Nurses Australia, JSCEOLC Transcript, 14 December 2017, Session 2 at 3-4; Dr Gibson, Chief Psychiatrist of Western Australia, JSCEOLC Transcript, 14 December 2017, Session 5 at 9; Mrs Clarke, Outreach Services Project Officer, Aboriginal Health Council of WA, JSCEOLC Transcript, 2 March 2018, Session 4 at 4.

27 Aoun et al (2017) 'Bereavement support for family caregivers: The gap between guidelines and practice in palliative care,' *PLoS ONE* 12(10): e0184750 <<https://doi.org/10.1371/journal.pone.0184750>> at 9 – citing McNamara, Rosenwax and Holman (2006) 'A method for defining and estimating the palliative care population' *J Pain Symptom Manage* 32(1) at 5-12; see also Palliative Care WA, JSCEOLC Responses to Questions on Notice, 19 December 2017 at 3.

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### Data on refractory symptoms

- 1.18. Proponents of legalised assisted suicide suggest that palliative care cannot alleviate the pain of everyone approaching their end of life, and therefore that voluntary euthanasia or physician-assisted suicide should be introduced to address that shortfall. A recurrent question raised in the Committee hearings was whether palliative care could be considered 100 per cent effective for all patients, and if not, could a figure be placed on the number of patients for whom symptoms cannot be managed, referred to as refractory symptoms.
- 1.19. As to whether palliative care could be considered 100 per cent effective for all patients, the common response was that no medical treatment is ever 100 per cent effective for all patients, including palliative care.<sup>28</sup>
- 1.20. Placing a figure on the number of people experiencing refractory symptoms at the end of life was an issue contested slightly more than the issue of whether or not palliative care is 100 per cent effective for all patients at end of life. Proponents of assisted suicide placed the figure at 5 per cent,<sup>29</sup> or between 5 and 10 per cent,<sup>30</sup> and even a guess as high as 30 per cent.<sup>31</sup>
- 1.21. A more conservative figure of 2 per cent was consistently given by palliative care specialists and those involved in palliative care service delivery.<sup>32</sup>
- 1.22. Conflicting interpretation of data on the incidence of refractory symptoms from the Palliative Care Outcomes Collaboration (PCOC) contributed to the disparity between the 2 per cent figure given by palliative care specialists, and the 5-10 per cent suggested by assisted suicide proponents.

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28 See Dr Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, JSCEOLC Transcript, 13 December 2017, Session 1 at 16; Mrs Buchanan, Committee Member, Palliative Care Nurses Australia, JSCEOLC Transcript, 14 December 2017, Session 2 at 10; Dr Campbell, President, Palliative Care WA, JSCEOLC Transcript, 14 December 2017, Session 4 at 8; Dr Tandon, Chairman, WA Palliative Medicine Specialists Group, JSCEOLC Transcript, 27 February 2018, Session 5 at 3; Mr Teale, Chief Executive, Council on the Ageing WA (Inc), JSCEOLC Transcript, 2 March 2018, Session 5 at 2; and Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 28 February 2018, Session 2 at 4.

29 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 7.

30 Dr Lugg, Doctors for Assisted Dying Choice, JSCEOLC Transcript, 26 February 2018, Session 4 at 3.

31 Dr Hennessy, Head of Anaesthesia Department, Sir Charles Gairdner Hospital, JSCEOLC Transcript, 30 April 2018, Session 1 at 3.

32 See Dr Campbell, President, Palliative Care WA, JSCEOLC Transcript, 14 December 2017, Session 4 at 8; Dr McNulty, Palliative Care Medical Specialist, JSCEOLC Transcript, 27 February 2017, Session 5 at 3 and Prof Evans, Chief Advisor, Public Policy, Silver Chain Group, JSCEOLC Transcript, 15 December 2017, Session 3 at 11. Dr Khorshid, while not placing a percentage figure, also suggested to the Committee that 'The number of people for whom palliative care is inadequate is very, very small. We acknowledge that there are some, but it is very small': Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, Session 1, 18 May 2018 at 14.

- 1.23. PCOC is a national program that uses standard clinical assessment tools across all states in Australia to measure and benchmark patient outcomes in palliative care. In interpreting this data collected by PCOC, there are some important things that must be considered.
- 1.24. Firstly, data submission to PCOC is not mandatory and only 14 specialist services, out of 22 specialist services in Western Australia, submit data to PCOC.<sup>33</sup> The Health Department warned that while the PCOC data is very valuable and important, it should not be assumed that it is representative of all services in Western Australia.<sup>34</sup> Further, the Symptom Distress Scores used to collect the data were designed for patient use, but also allowed for proxy ratings which is not a psychometrically valid technique for data collection and results obtained will differ.<sup>35</sup>
- 1.25. Secondly, assessment of pain symptoms is also very dependent upon the individual patient and their specific goals of care. The data does not take into account whether some patients chose not to take medication for pain relief. For example, there may be certain side effects that the patient may wish to avoid, or the patient may have religious convictions or other reasons for refusing pain relief medication.<sup>36</sup> Symptom assessment scales also do not consider the complex and highly individual nature of people's experiences of pain. For example, if a patient has complex psychosocial or existential distress, this can escalate a patient's physical pain symptoms.<sup>37</sup> If a patient's psychological and spiritual suffering has not been addressed, that makes the assessment of that patient's physical pain symptoms far more complex and cannot simply be attributed to a failure of palliative care to relieve physical pain.
- 1.26. Thirdly, whether patients are receiving adequate pain management is also dependent on whether there are enough specialist pain physicians and palliative care physicians available to meet patient demand. For example, accounts from patients were given to the Committee on a site visit to Sir Charles Gairdner Hospital that pain management was not being delivered particularly effectively and this was attributed to understaffing.<sup>38</sup> Symptoms should not be deemed refractory if the cause of the unrelieved symptoms is

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33 Ms Bolleter, Program Manager, Palliative Care, Department of Health, JSCEOLC Transcript, 13 December 2017, Session 1 at 4.

34 Ibid at 5.

35 Dr Tandon, Chairman, WA Palliative Medicine Specialists Group and Consultant Physician, Palliative Care Service, Sir Charles Gairdner Hospital, JSCEOLC Additional Answers to Questions on Notice, undated email.

36 Dr Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, JSCEOLC Transcript, 13 December 2017, Session 1 at 19; Dr Campbell, President, Palliative Care WA, JSCEOLC Transcript, 14 December 2017, Session 4 at 8 and Dr Tandon, Chairman, WA Palliative Medicine Specialists Group, JSCEOLC Transcript, 27 February 2018, Session 5 at 3.

37 Dr McNulty, Palliative Care Medical Specialist, Silver Chain, JSCEOLC Transcript, 27 February 2018, Session 5 at 5.

38 Hon Dr Sally Talbot, Committee Member, and Dr Hennessy, Head of Anaesthesia Department, Sir Charles Gairdner Hospital, JSCEOLC Transcript, 30 April 2018, Session 1 at 10.

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inadequate access to and provision of palliative care or failure to provide best practice therapies.<sup>39</sup>

- 1.27. To suggest that the figure of 2 per cent is representative of a failure of palliative care to manage physical pain symptoms fails to take these important considerations into account.
- 1.28. Furthermore, PCOC is a voluntary program and is primarily used for two purposes—research and benchmarking, that is, the comparison between one service and another. The validity of PCOC data across specialist palliative care more generally, and whether the data can be considered applicable across all palliative care services in Western Australia is therefore questionable.<sup>40</sup> If, however, it is accepted that the data is useful for benchmarking, Mr Richard Egan of Defend Human Life! suggests that the service provider with the lowest figures for unmanaged pain symptoms should be used as a ‘gold standard’ to determine best practice.<sup>41</sup> This would be the best use of the data, rather than to extrapolate an average figure for unmanaged pain symptoms across the entire palliative care sector.
- 1.29. It also does not follow that if the physical pain symptoms of some patients cannot be relieved by palliative care therapies that this necessitates the legalisation of assisted dying. Data collected from Oregon, where physician-assisted suicide has been legalised, has shown that physical pain is rarely ever cited as the reason for the request for assisted suicide. The Oregon Health Authority’s *Sixth Annual Report on Oregon’s Death with Dignity Act, 2004*, cites the reasons given by those people who have died under Oregon’s assisted suicide law as being:
- A steady loss of autonomy (91.4 per cent)
  - Less able to engage in activities making life enjoyable (89.7 per cent)
  - Loss of dignity (77 per cent)
  - Loss of control of bodily functions, such as incontinence and vomiting (46.8 per cent)
  - Physical or emotional burden on family, friends, or caregivers (42.2 per cent)
  - Inadequate pain control (26.3 per cent)

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39 Radruch et al (2013) ‘The Prague charter: urging governments to relieve suffering and ensure the right to palliative care’ *Palliative Medicine* 27 at 101-102, cited in Australia and New Zealand Specialist Palliative Medicine (ANZSPM) Guidance Document on Palliative Sedation Therapy, provided to the JSCEOLC as Supplementary Information by Dr Allison Parr, Director, Medical Services, St John of God Health Care, Palliative Medicine Consultant, 18 July 2017, at 1.

40 Dr Tandon, Chairman, WA Palliative Medicine Specialists Group, JSCEOLC Transcript, 27 February 2018, Session 5 at 4.

41 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Transcript, 9 March 2018, Session 1 at 2.

- 1.30. Earlier annual reports noted that ‘Patients discussing concern about inadequate pain control with their physicians were not necessarily experiencing pain.’<sup>42</sup> Very similar statistics are also found in the latest 2016 Oregon Health Authority Report.<sup>43</sup>
- 1.31. The experience in the Northern Territory also evidences similar reasons for patients accessing euthanasia while the *Rights of the Terminally Ill Act 1995* (NT) was in operation there. Kissane noted that ‘fatigue, frailty, depression and other symptoms,’ and not pain, were the prominent concerns of those patients who received euthanasia at that time.<sup>44</sup>
- 1.32. Breitbart et al also found no significant association between desire for hastened death and either the presence or absence of pain or pain intensity. The authors suggest that this finding may reflect the quality of pain management practiced by the study institution, or alternatively, that these results may simply confirm previous research that found little or no relationship between pain and desire for hastened death or interest in assisted suicide.<sup>45</sup> Other research also supports the conclusion that most patients requesting death do so not based on physical symptoms such as pain but rather based on depression and other forms of psychological distress.<sup>46</sup> The reasons someone requests assisted dying are complex and multifactorial. Psychological, existential and social motives are more striking features of requests to die than physical symptoms.<sup>47</sup>
- 1.33. Whether assisted suicide should be legalised in Western Australia by trying to determine an exact figure for the number of people who experience refractory symptoms in end of life care is not necessary, since the rejection of euthanasia is not dependent on the perfecting of palliative care. As Dr van Gend has noted, ‘We cannot ease all suffering in dying any more than we can ease all suffering in childbirth, even though we have made

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42 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5, at 2-3.

43 See Rev Dr Parkinson, Director, LJ Goody Bioethics Centre, JSCEOLC Submission 53 at 3. Nurses working in hospices in Oregon report that pain and pain control rated tenth in major drivers of desire for voluntary assisted dying (VAD) among hospice patients after desire to control the circumstances of death, the wish to die at home, loss of independence or fear of such loss, and loss of dignity or fear of such loss: Ganzini et al (2002) ‘Experiences of Oregon Nurses and Social Workers with Hospice Patients Who Requested Assistance with Suicide’ *New Engl J of Med* 347 at 582-588, cited by Rev Dr Parkinson, Director, LJ Goody Bioethics Centre, JSCEOLC Submission 53 at 3. See also Blank et al (2017) ‘Characterizing 18 Years of the Death With Dignity Act in Oregon,’ *JAMA Oncol* 3(10) 1403-1406.

44 Kissane, Street and Nitschke (1998) ‘Seven Deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia’ *The Lancet* 352 at 1097-102, cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 11.

45 Breitbart et al (2000) ‘Depression, Hopelessness and Desire for Hastened Death in Terminally Ill Patients with Cancer,’ *JAMA* 284, 2907-2911 at 2910.

46 Golden and Zoanni (2010) ‘Killing Us Softly: The Dangers of Legalizing Assisted Suicide’ *Disability and Health Journal* 3(1), 16-30, at 23. See also Pearlman et al (2005) ‘Motivations for Physician-assisted Suicide – Patient and Family Voices’ *Journal of General Internal Medicine* 20(3), 234-39 referenced by Rev Dr Parkinson, Director, LJ Goody Bioethics Centre, JSCEOLC Submission 53 at 3.

47 Sprung et al (2018) ‘Physician-Assisted Suicide and Euthanasia: Emerging Issues from a Global Perspective’ *Journal of Palliative Care* [sagepub.com/journalsPermissions.nav](http://sagepub.com/journalsPermissions.nav) DOI: 10.1177/0825859718777325 at 3.

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enormous progress... Rejection of euthanasia is not dependent on perfecting palliative care for all patients.<sup>48</sup>

- 1.34. The Professionalism and Human Rights Committee of the American College of Physicians put it another way:

*The suffering of dying patients may be great and is caused by somatic symptoms, such as pain and nausea; psychological conditions, such as depression or anxiety; interpersonal suffering due to dependency or unresolved conflict; or existential suffering based in hopelessness, indignity, or the belief that one's life has ended in a biographical sense but has not yet ended biologically. For some patients, a sense of control over the manner and timing of death brings comfort. However, is it reasonable to ask medicine to relieve all human suffering? Just as medicine cannot eliminate death, medicine cannot relieve all human suffering.<sup>49</sup>*

- 1.35. As Dr Megan Best articulated the issue:

*It is not about a failure of medicine. As I said, we have better palliative care than ever before. In my own career, there has been an exponential improvement in palliative care. So at this time where we can do so much for people who are dying, we have the loudest call for assisted death. I think it is about autonomy—people wanting to be able to control their death.<sup>50</sup>*

### **A comment on the Committee's inquiry into palliative care**

- 1.36. The Committee was asked by the Houses to assess the practices currently being utilised within the medical community to assist a person to exercise their preferences for the way they want to manage their end of life when experiencing chronic and/or terminal illnesses, including the role of palliative care.
- 1.37. The Committee has helpfully acknowledged the importance of access to specialist palliative care, the unhelpfulness of inconsistent data collection, the insufficient number of palliative care workers in Western Australia and the gap in care for those deemed not unwell enough to qualify for an inpatient hospice service. Of particular importance the

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48 Dr van Gend, "'Unproductive burdens' still have a right to live,' *The Australian*, 25 March 2011, quoted by Mr Randal, President, Coalition for the Defence of Human Life, Presentation to the Select Committee on End of Life Choices, included in JSCEOLC Response to Questions on Notice, 17 April 2018 at 3.

49 Snyder, Sulmasy and Mueller (2017) 'Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper,' Professionalism and Human Rights Committee of the American College of Physicians, *Annals of Int Med* 167(8) at 577.

50 Dr Best, Palliative Care Physician and Academic, JSCEOLC Transcript, 1 May 2018, Session 2 at 4.



Committee has recognised the need for greater community awareness of palliative care and made recommendations to assess the accessibility issue and improve education to health practitioners and the community.

- 1.38. It is regrettable, however, that the Committee has separated its reporting on palliative care from its reporting on lawful options at end of life. Medical treatment, including palliative care, is indeed a lawful option at end of life.
- 1.39. In addition it is unfortunate that the Committee has not rigorously engaged with the recommendations put to it by Western Australia’s peak body for palliative care.<sup>51</sup>
- 1.40. It is most regrettable that the Committee has not tested the veracity of its conclusion that too many Western Australians experience profound suffering as they die, even with access to the best quality palliative care available. There is no doubt that some Western Australians experience profound suffering as they die. This can occur when palliative care is not accessed. However, this can also occur in some instances when less than optimal palliative care is delivered.
- 1.41. These scenarios were plainly articulated to the Committee by Senior Palliative Care Specialist Professor Doug Bridge when he recounted several cases:

*A terminal patient—I do not quite like that word, but a man or a woman who is about to die—presented to the Southern Cross Hospital after hours. The patient was seen by emergency telehealth—that is by videoconferencing. The decision was made to admit the patient, but there was no doctor with admitting rights, so the patient was transferred to Merredin 109 kilometres away. Merredin had no admitting doctors so the patient was sent to Northam, 270 km from home. Northam had no beds, so the patient was transferred to Perth. The patient died alone in the ED in Perth 360 kilometres from home. Bad luck; tough; it cannot be helped—really? Can we not do better than that?*

...

*When I started doing this in 1983, there were no textbooks, no courses, no qualifications, no-one to turn to. Silver Chain said to me, “We’re about to start home care in Claremont. Occasionally, we will have a difficult patient we can’t look after. You’re a nice, kind physician in Fremantle Hospital. Would you take them in and look after them?” I naively said, “Yes, I’ll give it a go.” Shortly afterwards, my intern rang me on Saturday morning, “Doug, I can’t stop this guy’s pain. What*

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51 Ms Lana Glogowski, Executive Officer, Palliative Care WA, Letter to JSCEOLC, 18 May 2018.

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*should I do?" I said, "Give him some morphine." He said, "I have" so I said I would be there in five minutes. I came into the room, saw the ampoule and said, "What's this, David?" It was morphine sulphate, 30 milligrams. That is a big dose. I asked what he had done with it, and he said he had given it intravenously ... He had given him 20 ampoules of 30 milligrams in the last hour and he still wanted pain control. If you did not trust me, you would say this is rubbish; that is enough to kill an elephant. How could he give a man a massive, massive, massive overdose, intravenously? Highly dangerous! I had no idea. I was despairing. Now there is lots of research and knowledge and I would say, "This is easy, David; stop the morphine. He has opioid-induced hyperalgesia syndrome. The morphine backfires in the cell and makes it worse. Stop the morphine and give him methadone and ketamine. He'll be right in a few hours."<sup>52</sup>*

- 1.42. The Committee's hearings and submissions include multiple stories of Western Australians who suffered at end of life. It is important that these stories are heard. It is equally important that those stories are not misconstrued as evidence of the practice of palliative care being incapable of palliating the suffering of patients generally. Evidence of poorly practised palliative care is not evidence as to the efficacy of palliative care when practised properly. Patients with the most difficult cases need access to expertly practised specialist palliative care.

### **Finding 1**

Specialist palliative care is a relatively new discipline within the medical profession.

### **Finding 2**

Palliative care is poorly understood within the Western Australian community.

### **Finding 3**

The provision of quality palliative care affirms a patient's right to choose their therapy, decline futile treatment, choose their place of dying, receive the best possible relief of symptoms and to refuse to prolong the dying process.

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52 Prof Bridge, Senior Palliative Care Specialist, UWA Faculty of Medicine and Health Sciences; WA Country Health Service, Royal Perth Hospital, JSCEOLC Transcript, 9 March 2018, Session 5 at 4-5 (emphasis added).

#### **Finding 4**

Medical treatment, including palliative care is an end of life choice currently available in Western Australia, however:

- a) Patients with non-malignant diseases are under-represented in palliative care in WA; and
- b) access to good quality palliative care across the State is, in any event, currently highly variable.

#### **Finding 5**

Data from the Palliative Care Outcomes Collaboration (PCOC) can be useful in comparing one service provider with another but it is not, nor is it intended to be, an academically rigorous tool to assess palliative care generally.

#### **Recommendation 1**

The Minister for Health should consult with the Palliative Care Outcomes Collaboration (PCOC) and service providers to determine a data collection methodology that would set the lowest figures for unmanaged pain symptoms as the aspirational standard for every service provider.

#### **Recommendation 2**

The Minister for Health should consult with palliative care service providers to ascertain the current deficit in capacity preventing equitable provision of specialist palliative care across Western Australia.

#### **Recommendation 3**

The Minister for Health should assess the recommendations made by Western Australia's peak body for palliative care and report to Parliament with a plan to:

- a) utilise co-design workshops;
- b) progress the Compassionate Communities model;
- c) introduce shared care models;
- d) increase the capacity of the Silver Chain Hospice Care Service model of care;
- e) build the capacity of existing outpatient clinics to facilitate Advance Care Planning; and
- f) increase the availability and flexibility of Telehealth.

### **Refusal of Nutrition and Hydration**

- 1.43. Voluntary refusal of food and fluids occurs frequently as a normal part of the natural dying process,<sup>53</sup> and as such is often a scenario in which palliative care therapies will be offered, hence the term voluntary palliated starvation. It is legally and ethically possible

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53 Mr Cockayne, General Manager, Health Care WA, Silver Chain Group, JSCEOLC Transcript, 15 December 2017, Session 3 at 16.

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to provide palliative care throughout this process since the palliative care is provided with the intent of relieving suffering due to pain or other reasons associated with dehydration and malnutrition.<sup>54</sup> Providing pain relief to someone who is not swallowing is routinely done in palliative care.<sup>55</sup>

- 1.44. Dr Best gave evidence that the suggestion that patients are starved to death in palliative care units is a misunderstanding of the normal metabolic changes which occur at the end of life. Patients stop feeling hungry and indeed do not gain weight even if force fed, which is not done as it increases the discomfort of the patient (furthermore, forcing the patient to eat and drink would also breach their right to inviolability, which is considered further below).<sup>56</sup> All patients at the end of life will lose their appetite and lose either the ability to swallow safely or the interest to do so.<sup>57</sup> Often the refusal of food and fluids is a sign to medical practitioners that a patient is probably going to die fairly soon.<sup>58</sup>
- 1.45. Two Australian legal academics, Professors Lindy Willmott and Ben White, suggest that voluntary palliated starvation is a practice which is occurring more frequently in Australia because of the lack of options that patients have as they approach the end of their lives.<sup>59</sup> This statement was not supported in evidence given to the Committee from specialists in palliative care.
- 1.46. To voluntarily choose to stop eating and drinking, outside of the end stages of the natural dying process, is a choice that exists in Western Australia.<sup>60</sup> However, it is a choice that is very rarely made. In the clinical experience of the palliative care specialists who gave evidence to the committee, none had experienced a patient choosing to voluntarily refuse nutrition and hydration to bring about that patient's death.<sup>61</sup> Where patients had

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54 Dr Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, Department of Health, JSCEOLC Transcript, 13 December 2017, Session 1 at 24.

55 Dr Koh, Chair, Royal Australian College of General Practitioners, JSCEOLC Transcript, 15 December 2017, Session 1 at 11-12.

56 Dr Best, Palliative Care Physician and Academic, JSCEOLC Transcript, 1 May 2018, Session 1 at 2; see also Dr Koh, Chair, Royal Australian College of General Practitioners, JSCEOLC Transcript, 15 December 2017, Session 1 at 11.

57 Dr Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, Department of Health, JSCEOLC Transcript, 18 May 2018, Session 2 at 19.

58 Dr Koh, Chair, Royal Australian College of General Practitioners, JSCEOLC Transcript, 15 December 2017, Session 1 at 12.

59 Prof Willmott and Prof White, Directors, Australian Centre for Health Law Research, and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, JSCEOLC Submission 560 at 4.

60 Dr Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, Department of Health, JSCEOLC Transcript, 13 December 2017, Session 1 at 27.

61 The Department of Health recommended that the best people to seek evidence from on this issue were individual health service providers and/or Palliative Care Physicians through the WA Palliative Medicine Specialists Group (Department of Health, JSCEOLC Response to Questions on Notice, undated at 5). See Dr Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, Department of Health, JSCEOLC Transcript, 13 December 2017, Session 1 at 19; Dr McNulty, Palliative Care Medical Specialist, Silver Chain, JSCEOLC Transcript, 27 February

spoken about the option, or had started to refuse nutrition and hydration, they then decided that they did not actually want to go through with it.<sup>62</sup> Requests were not common, but were considered a good prompt by the palliative care professionals to talk to the person about their wishes and possibly commence the advance care planning process with them.<sup>63</sup>

- 1.47. Though rare, such requests for voluntary palliated starvation are ethically supported since the right to refuse treatment, or in this case nutrition and hydration, is based on a right to inviolability—a right not to be touched without one’s informed consent. It is not a right to die or a right to be killed. At most, people have a negative content right to be allowed to die, not any right to positive assistance to achieve that outcome.<sup>64</sup> The important legal principle here is the patient’s right to refuse treatment.<sup>65</sup> To prevent someone of sound mind from refusing nutrition and hydration would involve the forceful introduction of nutrition and hydration through medical treatment, against the wishes of the individual.
- 1.48. The State Coroner of Western Australia did not consider a death by palliative starvation as a suicide, or a death brought about by an act of self-destruction being an intentional act by a person knowing the probably consequences of their actions. The refusal of hydration and nutrition was not considered by the Coroner as an act of suicide since a person of sound mind can decide not to keep eating and drinking, and was regarded as a decision to allow a natural illness to progress.<sup>66</sup> Though not expecting to see starvation or dehydration on a death certificate in end of life cases, the Chief Registrar did note that it is quite common to see inanition on the death certificates of those who have died

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2018, Session 5 at 7; Dr Tandon, Chairman, WA Palliative Medicine Specialists Group, JSCEOLC Transcript, 27 February 2018, Session 5 at 8; and Dr Parr, Director, Medical Services, St John of God Health Care and Palliative Medicine Consultant, JSCEOLC Transcript, 28 February 2018, Session 1 at 12 and 13.

62 See Dr Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, Department of Health, JSCEOLC Transcript, 13 December 2017, Session 1 at 19; Dr McNulty, Palliative Care Medical Specialist, Silver Chain, JSCEOLC Transcript, 27 February 2018, Session 5 at 7; Dr Parr, Director, Medical Services, St John of God Health Care and Palliative Medicine Consultant, JSCEOLC Transcript, 28 February 2018, Session 1 at 12.

63 Dr Campbell, President, Palliative Care WA, JSCEOLC Transcript, 14 December 2017, Session 4 at 10; Dr Parr, Director, Medical Services, St John of God Health Care and Palliative Medicine Consultant, JSCEOLC Transcript, 28 February 2018, Session 1 at 12 and 13; Ms Brady, Executive Manager, Mission, Catholic Homes WA, JSCEOLC Transcript, 28 February 2018, Session 1 at 12.

64 Boudreau and Somerville (2013) ‘Euthanasia is not medical treatment’ *British Medical Bulletin* 106, 45-66 at 60.

65 Prof Bridge, Senior Palliative Care Specialist, UWA Faculty of Medicine and Health Sciences; WA Country Health Service, Royal Perth Hospital, JSCEOLC Transcript, 9 March 2018, Session 5 at 11.

66 Ms Fogliani, State Coroner of Western Australia, JSCEOLC Transcript, 1 March 2018, Session 1 at 11. This was also reflected in the evidence of Ms Wagland, General Manager, Community, Brightwater Care Group, JSCEOLC Transcript, 1 March 2018, Session 2 at 6.

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suffering from dementia, as a person starving themselves to death is a known consequence of dementia.<sup>67</sup>

- 1.49. Professor Michael Francis Quinlan, Consultant General Physician and Professor of Medicine at the University of Notre Dame Australia (UNDA) and former Clinical Professor of Medicine at the University of Western Australia (UWA), also distinguished the refusal of hydration and nutrition from a suicide attempt since it is voluntary and it is reversible if the patient so chooses it.<sup>68</sup>
- 1.50. Contrary to the opinion given by Mr Andrew Denton of Go Gentle Australia, who suggested that palliated starvation and dehydration is a ‘slow and painful’ means of hastening death and ‘long, slow, and psychologically painful for the person going through it, their family and the medical team caring for them,’<sup>69</sup> evidence given to the Committee by medical professionals indicated that it can be ‘a moderately peaceful way to die as long as good associated palliative care is also given,’<sup>70</sup> and that ‘when a person stops eating and drinking...they actually enter into a peaceful state, where the ketones and other chemicals from fasting allow the mind to be clear and relaxed.’<sup>71</sup>
- 1.51. Evidence was also given to the Committee that a peer reviewed study conducted in Oregon, comparing the deaths of 102 patients who had voluntarily stopped eating or drinking until they died with the deaths of 55 patients who had died from physician-assisted suicide, concluded that the deaths of those who had voluntarily stopped eating or drinking were considered more peaceful and more comfortable than those by assisted suicide.<sup>72</sup> Dr Rodney Syme, despite being a vocal proponent of euthanasia, wrote in his book *A Good Death: An Argument for Voluntary Euthanasia* (2008), that he was surprised to find how peaceful death by voluntary palliated starvation is, and that it is a choice legally available to patients, but one that is simply too slow.<sup>73</sup>

### Finding 6

Loss of hunger and thirst occurs frequently as a normal part of the natural dying process.

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67 Mr Cooper, Principal Registrar, Coroner’s Court of Western Australia, JSCEOLC Transcript, 1 March 2018, Session 1 at 12.

68 Prof Quinlan, Consultant General Physician, JSCEOLC Transcript, 1 March 2018, Session 4 at 5.

69 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 6 and 10.

70 Prof Quinlan, Consultant General Physician, JSCEOLC Transcript, 1 March 2018, Session 4 at 5-6.

71 Prof Bridge, Senior Palliative Care Specialist, UWA Faculty of Medicine and Health Sciences; WA Country Health Service, Royal Perth Hospital, JSCEOLC Transcript, 9 March 2018, Session 5 at 5.

72 Ibid at 6.

73 Dr Syme, *A Good Death: An Argument for Voluntary Euthanasia* (2008) – referred to by Prof Bridge, Senior Palliative Care Specialist, UWA Faculty of Medicine and Health Sciences; WA Country Health Service, Royal Perth Hospital, JSCEOLC Transcript, 9 March 2018, Session 5 at 6.

**Finding 7**

Refusal of nutrition and hydration is an end of life choice currently available in Western Australia, however it is significantly distinguishable from assisted suicide as it is based on the right to inviolability and is in any case reversible.

**Refusal of Medical Treatment**

- 1.52. A patient has the right to refuse medical treatment including in order not to prolong the dying process. This current end of life option should not be conflated with assisted suicide.
- 1.53. An example of an emphysema patient given by Doctors for Assisted Dying Choice in their submission to the Committee is actually an example of refusal of medical treatment, accompanied by good medical care:

*when the time came she removed her oxygen and was fitted with a subcutaneous catheter through which was administered standard sedation. By midnight she was unconscious and by 11.30am the next day she took her last breath aged 74.<sup>74</sup>*

- 1.54. This patient's death was caused by her underlying condition (emphysema). The patient was entitled to refuse medical treatment (prescribed continuous oxygen). The patient was also entitled to give informed consent to palliative sedation to manage her symptoms and reduce pain and suffering associated with the emphysema.
- 1.55. The Doctors for Assisted Dying Choice example is almost identical to an example given by Professor Bridge:

*This man was about 70. He had advanced lung cancer. He was dying. He was kept alive by a breathing machine for some days. He said one day, "I've had enough. Just turn me off." I spoke to him at some length. I spoke to his family. We had long conversations. We agreed it was okay. So in the morning, peacefully, with the family present, he was given extra sedation, he was relaxed and unconscious, the mask was taken off, and he died peacefully a few minutes later ... I do not think we need to change the law to allow it to happen. We need to educate doctors and nurses that it is okay.<sup>75</sup>*

- 1.56. Professor Kirsten Auret, Academic in Palliative Care at the University of Western Australia, suggests that '[i]n old terminology, that may have been called passive

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74 Doctors for Assisted Dying Choice, JSCEOLC Submission 402 at 9.

75 Prof Bridge, Senior Palliative Care Specialist, UWA Faculty of Medicine and Health Sciences; WA Country Health Service, Royal Perth Hospital, JSCEOLC Transcript, 9 March 2018, Session 5 at 7.

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euthanasia, allowing that to happen, where now we would call that good medical practice.<sup>76</sup>

- 1.57. A palliative care physician, Dr Best explained in evidence to the Committee that treatment initially aimed at cure may become futile in a life-threatening illness; that is, it stops working, or is so burdensome, due to distressing side effects like vomiting, that any benefit from the treatment is no longer worthwhile. The treatment may be no longer prolonging life so much as prolonging the process of dying. At this time a decision may be made with the patient to stop such a treatment. This practice is not euthanasia, because the intention is not to kill the patient but to allow the underlying disease to take its natural course and full supported care will remain in place so the patient is kept comfortable. In the same way, ‘taking someone off life support’ is not euthanasia. It is not flicking the switch that kills the patient, it is the underlying disease that does it.<sup>77</sup>
- 1.58. Patients are not always aware that this choice is available to them. Dr Keiron Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, gave the following example:

*I had someone who came in the other day who is on a lot of heart medicines. He came in and said, “I want to die.” In actual fact when we explored it, he had not ever realised that he could stop this whole host of heart medicines that he was on, including intravenous medicines and subcutaneous. So when he realised that, when we talked it through with him, it was this huge relief to him that he could stop them.<sup>78</sup>*

- 1.59. Dr Best also gave evidence that many people are not aware of the choice to refuse futile medical treatment which leads to the prolonging of suffering:

*We have a lot of people in the community who do not realise that they actually have a choice to stop treatment which is not aimed at cure because of the burden of side effects. In my own practice, time and time again I have seen people who did not realise that they could stop treatment if they wanted to and be more comfortable, and rather than spend their time in hospital spend their time at home with the dog. Even looking at the book of stories of suffering from Go Gentle—I think it was called The Damage Done—there are examples in that of people who suffered because they continued with treatment which they had the opportunity to stop but continued partly because they felt it was aimed*

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76 Prof Auret, Academic in Palliative Care, University of Western Australia, JSCEOLC Transcript, 1 March 2018, Session 3 at 5-6 (emphasis added).

77 Dr Best, Palliative Care Physician and Academic, JSCEOLC Transcript, 1 May 2018, Session 2 at 2.

78 Dr Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, Department of Health, JSCEOLC Transcript, 18 May 2018, Session 2 at 27.



*at cure, and sometimes because family members are scared of losing the person who is dying and may urge them to continue with chemotherapy which is ultimately futile in purpose.*<sup>79</sup>

- 1.60. In her evidence to the Committee, Ms Janet Wagland, General Manager of Brightwater Care Group, gave evidence that people with Huntington's disease regularly forgo the placement of a PEG to allow artificial nutrition and hydration. This is considered an important patient choice:

*The people from the Huntington's community, when you have those conversations, to them it gives them something real to be making choices that they know will have an improved longer term outcome for them depending on what they see as improved. If they would prefer to have a PEG inserted and be fed through central means, and they feel that that gives them longer with their families, for them, that is an improved outcome. For those who do not want to go through the suffering of really not being able to contribute and interact with their environment, which is often what the end result is, they will choose to not have the PEG inserted.*<sup>80</sup>

- 1.61. White, Willmott and Savulescu note that palliative care may be lawfully provided to a patient as they approach death to manage their pain and symptoms.<sup>81</sup> They refer to the decision in *Brightwater Care Group (Inc) v Rossiter*, which makes clear that this position does not change just because the death is occurring due to a refusal of treatment:

*There are a number of general principles which can be confidently stated in relation to this issue. The first is that the legal rights and obligations relating to the provision of palliative care are unaffected by the circumstance that the occasion for the provision of that care comes about as a consequence of Mr Rossiter's withdrawal of consent to the continuing provision of other medical treatment, namely, the provision of nutrition and hydration. Put another way, Dr Benstead's rights and obligations with respect to the provision of palliative care to Mr Rossiter if and when he directs Brightwater to discontinue the provision of*

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79 Dr Best, Palliative Care Physician and Academic, JSCEOLC Transcript, 1 May 2017, Session 2 at 6.

80 Ms Wagland, General Manager, Community, Brightwater Care Group, JSCEOLC Transcript, 1 March 2018, Session 2 at 8.

81 White, Willmott and Savulescu (2014) 'Voluntary palliated starvation: A lawful and ethical way to die?' (2014) 22 *Journal of Law and Medicine* 276-386 at 382, provided by Prof Willmott and Prof White, Directors, Australian Centre for Health Law Research, and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, in JSCEOLC Submission 560.

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*nutrition and hydration are no different to the obligations which attend the treatment of any other patient who may be approaching death.*<sup>82</sup>

- 1.62. Similarly, it would be lawful (as well as good and acceptable medical practice) to relieve the suffering of a person dying from a valid refusal of blood transfusion, such as a Jehovah's Witness. It is the fact of the suffering that is relevant, not its origin.<sup>83</sup>
- 1.63. Mr Denton suggests that '[i]n allowing someone the legal right to refuse life-sustaining treatment we have already accepted the principle that a dying person has a right to hasten their own death.'<sup>84</sup> However, like the voluntary refusal of nutrition and hydration, a right to refuse treatment is based on the right to inviolability—a right not to be touched without one's informed consent. It is not a right to die or a right to be killed. At most, people have a negative content right to be allowed to die, not any right to positive assistance to achieve that outcome.<sup>85</sup> Again, the important legal principle here is what is the patient's right—the patient always has the right to decline treatment.<sup>86</sup>
- 1.64. Assisted suicide is said to be different from the refusal of medical treatment, both in its nature and its intention. Death is the sole intended and inevitable outcome of assisted suicide. It is not due to any natural cause, even in those with a terminal illness, but is artificially induced so that a new and otherwise impossible cause of death has been substituted for the one which was to be expected. From both ethical and legal viewpoints, making a person die is different from letting a person die when it is medically proper to do so.<sup>87</sup>
- 1.65. Medical ethics and law strongly support a patient's right to refuse treatment, including life sustaining treatment. The intent is to avoid or withdraw treatment that the patient

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82 *Brightwater Care Group (Inc) v Rossiter* (2009) 40 WAR 84 at [52].

83 White, Willmott and Savulescu (2014) 'Voluntary palliated starvation: A lawful and ethical way to die?' (2014) 22 *Journal of Law and Medicine* 276-386 at 382, provided by Prof Willmott and Prof White, Directors, Australian Centre for Health Law Research, and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, in JSCEOLC Submission 560. It is noted here that despite the *Rossiter* judgment clearly expounding the law on refusal or withdrawal of medical treatment, Mr Rossiter did not choose to have his PEG tube withdrawn and died from natural causes: Prof Quinlan, Consultant General Physician, JSCEOLC Transcript, 1 March 2018, Session 4 at 6.

84 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 10.

85 Boudreau and Somerville (2013) 'Euthanasia is not medical treatment,' *British Medical Bulletin* 106, 45-66 at 60. See also Snyder, Sulmasy and Mueller (2017) 'Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper,' Professionalism and Human Rights Committee of the American College of Physicians, *Annals of Int Med* 167(8) 576.

86 Prof Bridge, Senior Palliative Care Specialist, UWA Faculty of Medicine and Health Sciences; WA Country Health Service, Royal Perth Hospital, JSCEOLC Transcript, 9 March 2018, Session 5 at 11.

87 Pollard and Winton (1993) 'Why doctors and nurses must not kill patients' *MJA* 158, 426-429 at 426.

judges to be inconsistent with his or her goals and preferences. Death follows naturally, after the refusal, as a result of the underlying disease.<sup>88</sup>

### Finding 8

Refusal of medical treatment is an end of life choice currently available in Western Australia, however it is significantly distinguishable from assisted suicide as it is based on the right to inviolability and is in any case reversible.

## Palliative Sedation

### Palliative sedation therapy and terminal sedation—terminology that can confuse

- 1.66. At the outset it is important to clarify the terminology used to describe ‘palliative sedation’ and to clear up confusion caused by the use of the term ‘terminal sedation.’ It was brought to the Committee’s attention that even in specialist fields people do not always refer to exactly the same thing when using those terms.<sup>89</sup>
- 1.67. ‘Palliative sedation’ is the provision of sedatives in the terminal phase of life and is not the termination of that person’s life. Palliative sedation is not done with the intent of bringing about the end of someone’s life, but is administered in order to relieve the patient from the suffering of refractory symptoms.<sup>90</sup>
- 1.68. The submission from Doctors for Assisted Dying Choice raised a local case: ‘[i]n 2016 a Perth doctor... became the subject of a police murder investigation after she described her management of a dying elderly woman suffering with end stage lung disease using terminal sedation.’<sup>91</sup> The doctor defended her claimed actions by stating that the patient was in the end stages of her disease, was suffering from extreme breathlessness, and had previously attempted suicide.<sup>92</sup>
- 1.69. It should be noted that the doctor was not a palliative care specialist. Silver Chain noted in their evidence to the Committee that where a patient’s symptoms become

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88 Snyder, Sulmasy and Mueller (2017) ‘Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper,’ Professionalism and Human Rights Committee of the American College of Physicians, *Annals of Int Med* 167(8) 576 at 577. This was supported in evidence given to the Committee by Mr Belcher, CEO Braemar Presbyterian Care, JSCEOLC Transcript, 27 February 2018, Session 2 at 10; and Dr Tandon, Chairman, WA Palliative Medicine Specialists Group, JSCEOLC Transcript, 27 February 2018, Session 5 at 13.

89 Dr Parr, Director, Medical Services, St John of God Health Care and Palliative Medicine Consultant, JSCEOLC Transcript, 28 February 2018, Session 1 at 13.

90 See Dr Koh, Chair, Royal Australian College of General Practitioners, JSCEOLC Transcript, 15 December 2017, Session 1 at 14; Dr Campbell, President, Palliative Care WA, JSCEOLC Transcript, 14 December 2017, Session 4 at 10 and 11 and Palliative Care Nurses Australia, Jane Phillips, President, JSCEOLC Response to Questions on Notice, 29 January 2018 at 3, 4 and 5.

91 Doctors for Assisted Dying Choice, JSCEOLC Submission 402 at 7.

92 Dr Alida Lancée, ‘Sometimes one needs to stand up for what’s right,’ in *The Damage Done* (2016), Go Gentle Australia at 128-130.

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unmanageable in a community palliative care setting, they will refer or transfer the patient to a specialist palliative care unit.<sup>93</sup>

- 1.70. It would also appear that the doctor's claimed action does not fit within accepted palliative sedation practice as described by Palliative Care Victoria:

*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. ...a small minority of patients experience refractory symptoms such as agitated delirium, difficulties breathing, pain and convulsions. Refractory symptoms are defined as: "pain or other symptoms for which all possible treatment has failed, or it is estimated that no methods are available for palliation within the time frame and the risk-benefit ratio that the patient can tolerate." A patient with refractory (unrelieved) distress "must have received skilled multidimensional management directed at the physical, psychological and existential dimensions of the symptom before a symptom is considered refractory." Prudent application of palliative sedation therapy may be used in the care of selected palliative care patients with otherwise refractory distress. [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.<sup>94</sup>*

- 1.71. The doctor's claimed action also appears to be contrary to the practice advocated by Palliative Care WA, which is that:

*Terminal sedation is sedation designed to relieve extreme distress in a person who is imminently dying, usually the last hours or days of life. Sedation should be appropriately used for the control of specific symptoms once all other alternatives have been considered and found to be ineffective or inapplicable. The most common refractory*

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93 Prof Evans, Chief Advisor, Public Policy, Silver Chain Group, JSCEOLC Transcript, 14 December 2017, Session 3 at 12.

94 Palliative Care Victoria (2015) *Submission to the Legal and Social Issues Committee Inquiry into End of Life Choices*, Submission 236 at 14-15, as quoted by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5, at 2 (emphasis added).

*symptoms requiring sedation are reported as delirium, which is acute confusion often characterised by agitation (54%) and breathlessness (30%) ... a systematic review by Maltoni and colleagues ... found no evidence that terminal sedation led to hastened death. The palliative care approach advocates managing the dying person's symptoms in the terminal phase in order to relieve suffering and maintain dignity.<sup>95</sup>*

- 1.72. Much evidence was heard by the Committee that palliative sedation does not hasten death. Palliative sedation occurs in patients at the end of their life; death is not hastened as it is already occurring due to the underlying medical condition and the research evidence supports this.<sup>96</sup>
- 1.73. Dr Timothy Koh, Chair of the Royal Australian College General Practitioners (RACGP), described the clear distinction between palliative sedation and assisted suicide in this way:

*In practice, we are just treating the symptoms, so this is not setting it up as a sort of way of committing euthanasia as far as I can see, basically. There is probably a distinction between those two things, I think. We are really looking at the patient and the needs of the patient and treating those needs but not with the intent of bringing about the end of someone's life.<sup>97</sup>*

### **Palliative sedation does not hasten death**

- 1.74. Palliative sedation is not considered to hasten death; in fact the opposite may be true—that is, that if someone's distressing symptoms at end of life are not treated, that in itself can hasten death. In other words, having uncontrolled pain or agitation can hasten death and shorten life.<sup>98</sup> Dr Elissa Campbell, President of Palliative Care WA, gave evidence to the Committee of an Australian study from a palliative care unit that looked at doses of sedating medications and opioid medications in people in the palliative care unit who died. There was no evidence that the doses of the medication were related to the life expectancy of the people in the hospice. She concludes that the use of these medications, in good quality palliative care, does not hasten death.<sup>99</sup>

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95 Palliative Care WA, JSCEOLC Response to Questions on Notice, 19 December 2017 at 8.

96 Dr Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, Department of Health, JSCEOLC Transcript, 13 December 2017, Session 1 at 29.

97 Dr Koh, Chair, Royal Australian College of General Practitioners, JSCEOLC Transcript, 15 December 2017, Session 1 at 13.

98 Dr Campbell, President, Palliative Care WA, JSCEOLC Transcript, 14 December 2017, Session 4 at 10.

99 Ibid at 11. See also Dr Parr, Director, Medical Services, St John of God Health Care and Palliative Medicine Consultant, JSCEOLC Transcript, 28 February 2018, Session 1 at 14 and her comments on the Maltoni study.

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- 1.75. As to whether palliative sedation medications should be recorded as a cause of, or contributing to, death on the death certificate, Dr Anil Tandon, Chairman of the WA Palliative Medicine Specialists Group, advised:

*In the care of a person dying from an irreversible medical condition, the use of sedating or pain-relieving medications are part of standard medical practice and should not be included as a cause of or contributing to the death on the death certificate. Such an inclusion would not be factually correct and would cause undue distress to the family and caregivers of the deceased person. We do not record the medication as the cause or a contributing factor to the death because the disease is the cause and the medications have not contributed to the death, they have only eased the symptoms prior to the death ... If there is doubt as to the contribution of pain relief medication to the death of a person, that death should be reported to the Coroner. If, however, the doctor is of the opinion that the pain relief medications were given for a clinically appropriate indication and at clinically appropriate doses, then they would not be the cause of death.<sup>100</sup>*

- 1.76. Dr Omar Khorshid, President of the Western Australia branch of the Australian Medical Association (AMA(WA)), also confirmed that palliative sedation medications would rarely, if ever, be recorded as contributing to the death, because it is the disease that led to the death.<sup>101</sup>
- 1.77. Dr Tandon went on to state that in the practice of caring for people with irreversible conditions who are expected to die, the only difference between patients who have received sedating or pain-relieving medications and those who have not is the degree of pain and other distress, not the timing of their death, and he notes that this has been confirmed in numerous settings by independent researchers.<sup>102</sup> Dr Tandon also provided a collection of studies from research undertaken over the past 20 years into the use of pain medicines and sedatives at the end of life which have demonstrated repeatedly that the use of these medications does not hasten death, including a landmark study published in 2010 which demonstrated in a select group of patients with lung cancer, that their survival was actually longer with palliative care than without.<sup>103</sup>
- 1.78. Dr Mary McNulty, Palliative Care Medical Specialist, put it succinctly in her evidence to the Committee that '[t]he sedation will not take my life any more quickly; it is just that

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100 Dr Tandon, Chairman, WA Palliative Medicine Specialists Group, JSCEOLC Response to Questions on Notice, 29 April 2018 at 1.

101 Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 28 February 2018, Session 2 at 6

102 Dr Tandon, Chairman, WA Palliative Medicine Specialists Group, JSCEOLC Response to Questions on Notice, 29 April 2018 at 2.

103 See Dr Tandon, Chairman, WA Palliative Medicine Specialists Group, JSCEOLC Transcript, 27 February 2018, Session 5 at 6.

the nature of how I die will change.<sup>104</sup> This is also in line with what is taught in medical schools, where the idea of proportionality is very firmly placed within the definition of palliative sedation taught to students, and that unconsciousness may be the aim of palliative sedation and that the patient will die during that period of unconsciousness.<sup>105</sup>

- 1.79. The criticism of palliative sedation raised by Dr Peter Beahan in evidence to the Committee was that it is not always possible to determine whether a patient who has received terminal sedation still suffers with physical or psychological pain, but Dr Beahan did not present any peer reviewed evidence to support this claim and admitted that ‘we do not really know because the patients cannot tell us.’<sup>106</sup> He went on to state that ‘the risk of continued suffering would be more likely with lighter levels of sedation. Heavier sedation may be more effective, but also more likely to shorten life.’<sup>107</sup>
- 1.80. Lighter levels of palliative sedation that do not address the distress and refractory symptoms experienced by the patient would be considered poor palliative sedation. Further, Dr Beahan’s evidence that using heavier sedation to adequately address these symptoms is more likely to shorten life is not supported by evidence provided to the Committee from palliative care specialists above, and indeed there is extensive research to the contrary. It should also be noted that neither Dr Beahan, nor his colleagues who gave evidence alongside him to the Committee on behalf of Doctors for Assisted Dying Choice, have any medical experience in the practice of palliative sedation.<sup>108</sup>
- 1.81. Dr Alida Lancée asserted to the Committee that ‘there is no evidence that sedating someone actually stops their suffering,’ and referred to the Cochrane review and the conclusion drawn that there is insufficient evidence about the efficacy of terminal sedation in terms of a person’s quality of life or symptom control.<sup>109</sup> However, a proper and full consideration of the Cochrane review and the conclusions drawn by that review reveal that the review concluded ‘No studies measured quality of life or participant well being, which was the primary outcome of the review’ and that ‘Further studies that specifically measure the efficacy and quality of life in sedated people... and quantify adverse effects are required.’<sup>110</sup> The conclusion that there is a lack of studies demonstrating that palliative sedation relieves a patient’s suffering,

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104 Dr McNulty, Palliative Care Medical Specialist, Silver Chain, JSCEOLC Transcript, 27 February 2018, Session 5 at 17.

105 Prof Auret, Academic in Palliative Care, University of Western Australia, JSCEOLC Transcript, 1 March 2018, Session 3 at 4.

106 Dr Beahan, Doctors for Assisted Dying Choice, JSCEOLC Transcript, 26 February 2018, Session 4 at 6.

107 Ibid.

108 See JSCEOLC Transcript, 26 February 2018, Session 4, at 7.

109 Dr Lancée, Medical Practitioner, Doctors for Assisted Dying Choice, JSCEOLC Transcript, 2 March 2018, Session 3 at 5.

110 Beller et al (2015) ‘Palliative pharmacological sedation for terminally ill adults (Review)’ Cochrane Database of Systematic Reviews 1 CD010206 DOI 10.1002/14651858 at 3.

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the actual conclusion drawn by the Cochrane review, is very different from the assertion made by Dr Lancée that there is no evidence that sedating someone actually stops their suffering, and the unsupported inference that therefore patients undergoing palliative sedation treatment are still suffering.

### **Palliative sedation is a conventional medical practice in care for the dying**

- 1.82. Another criticism made of palliative sedation by proponents of euthanasia is that the medical practice of palliative sedation is a dangerous and unregulated practice, which allows some doctors to euthanise patients ‘behind closed doors’.<sup>111</sup> Indeed the submission of Mr Ian Wood referred to palliative sedation as ‘terminal sedation’ and questioned whether it constitutes ‘slow euthanasia’ in current palliative care service provision in Australia.<sup>112</sup> However later in the same submission, when referring to the conclusions drawn by the Quebec Parliamentary Inquiry 2012 and the findings with regard to the incidence of those ‘euthanised without consent’ in Belgium, Mr Wood writes:

*It is false to say that many patients are euthanised without their consent. These patients receive continuous palliative sedation when they are unable to express consent, when they are dying, and when the doctor and family believe that it is the best way to ease their suffering.*<sup>113</sup>

- 1.83. It would appear therefore that for some proponents what is considered ‘slow euthanasia’ and a dangerous and unregulated practice when it occurs in Australia, is considered standard ‘palliative sedation’ when practiced in a country where euthanasia has been legalised. This once again highlights the power and the danger of terminology being conflated in this debate.
- 1.84. The same inconsistency is evident in the Go Gentle Australia submission made by Mr Denton. In discussing the rates of ‘life-terminating acts without explicit request’ (LAWER) in Belgium and the Netherlands, which are frequently cited by opponents of euthanasia as evidence of abuse in those countries, Mr Denton suggests that the rates in these countries may not even be as high as the statistics indicate since in Belgium ‘as in the Netherlands, more specific research into LAWER deaths... further clarified that physicians were, in fact, describing standard clinical management practices of dying patients in the last days and hours of life. These findings raised questions about whether these acts are truly equivalent to non-voluntary termination of life.’<sup>114</sup> And yet, earlier in

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111 Dr Alida Lancée in JSCEOLC Transcript, 2 March 2018, Session 3 at 4.

112 Mr Wood, Christians Supporting Choice for Voluntary Euthanasia, JSCEOLC Submission 25 at 11.

113 Ibid at 14.

114 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 6.Part E 17.



his submission Mr Denton describes the ‘widely practised’ treatment of ‘terminal sedation’ in Australia as the:

*practice of drugging dying patients into a coma in order to alleviate suffering [that] is “not centrally recorded, the extent of its use is unknown, and no guidelines exist to regulate it” ...Doctors sign certificates every day where death was the result of sedation and withholding hydration. Who would know if the doctrine of double effect is shielding abuse or cover up? No one is examining, or vouching for, the doctors’ intentions, yet we are told that this system is safer than one where doctors actions are guided by regulations and held accountable by law.*<sup>115</sup>

- 1.85. So yet again, what is ‘standard clinical management practice in caring for dying patients in their last days and hours,’ and does not necessitate reporting in one jurisdiction is a dangerous, unregulated and unreported practice in another jurisdiction. The only difference, seemingly, being the legal status of euthanasia in those countries.
- 1.86. The inconsistency by these proponents, none of whom are palliative care specialists, only creates confusion. Their evidence obscures what is a standard medical practice in palliative care in Australia and contradicts the breadth of evidence provided to the Committee on the practice of palliative sedation as it occurs in Western Australia. Evidence provided to the Committee included international guidelines for the use of palliative sedation with clear recommended clinical actions that have been adopted by palliative care bodies in Australia.<sup>116</sup> Evidence was also given to the Committee that palliative sedation therapies are medical decisions that are always made in partnership between the patient and their doctor, or with the patient’s substitute decision-maker where the consent of the patient cannot be obtained.<sup>117</sup>
- 1.87. In practice, opioids are titrated, either up or down, according to the response of the patient and the titration process can be either gradual, such as once a week, or as often

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115 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 9.

116 See the international guidelines on palliative care contained in Cherny and Radbruch (2009) ‘European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care’ *Palliat Med* 23(7) 581-93 – provided to the Committee by Palliative Care Nurses Australia Inc, Jane Phillips, President, JSCEOLC Response to Questions on Notice, 29 January 2018 at 3; and the Australia and New Zealand Specialist Palliative Medicine (ANZSPM) Guidance Document on Palliative Sedation Therapy, provided to the JSCEOLC as Supplementary Information by Dr Parr, Director, Medical Services, St John of God Health Care and Palliative Medicine Consultant, 18 July 2017 at 2.

117 See Dr Tandon, Chairman, WA Palliative Medicine Specialists Group, JSCEOLC Response to Questions on Notice, 29 April 2018 at 3; Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 18 May 2018, Session 1 at 26 and Dr Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, Department of Health, JSCEOLC Transcript, 13 December 2017, Session 1 at 29.

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as several times in one day if clinically appropriate. Low doses should be used initially if the pain is not severe or if there are concerns about the ability of the patient to tolerate any potential adverse effects. In all cases, the intention of the titration process is to minimise the duration that a patient is in distress.<sup>118</sup> Not only are the medications specially titrated according to the response of the patient, the medications are also reversible.<sup>119</sup>

### **The doctrine of double effect is not relied on in palliative sedation**

- 1.88. Confusion is also extended by proponents of assisted suicide to the application of the doctrine of double effect as it was expounded by Devlin J in *R v Adams*.<sup>120</sup> It is argued that palliative sedation involves the hastening of the death of the patient, and that it is a legal medical practice only because of the application of the doctrine of double effect—that the death of the patient was not intended by the medical practitioner, that the medical practitioner’s intent was to relieve the suffering of the patient.<sup>121</sup>
- 1.89. However, the experience of the hospice and palliative care movement over the past three decades has shown that the safe and effective use of morphine, and other opioids, and sedatives in pain and symptom control need not bring cause of death into question.<sup>122</sup> Again, many studies have proven that palliative sedation does not hasten or cause death. There is no clinical scientific evidence that morphine causes death and the respiratory depressant effects of morphine have been shown to be minimal.<sup>123</sup> This was

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118 Dr Tandon, Chairman, WA Palliative Medicine Specialists Group, JSCEOLC Response to Questions on Notice, 29 April 2018 at 2. See also St John of God Health Care, JSCEOLC Response to Questions on Notice, undated, at 1 and Dr Parr, Director Medical Services, St John of God Health Care and Palliative Medicine Consultant, JSCEOLC Transcript, 28 February 2018, Session 1 at 15.

119 See the discussion with Dr Hennessy in JSCEOLC Transcript, 30 April 2018, Session 1 at 9 regarding how to reverse the effects of opioids and other drugs and the statements made by Dr Tandon regarding the practice of using high doses of medications to stabilise a patient’s symptoms, and then for those drugs to be ceased and for the patient to resume an active life within the limits of their medical condition in WA Palliative Medicine Specialists Group, JSCEOLC Response to Questions on Notice, 29 April 2018 at 1.

120 *R v Adams* [1957] Crim LR 365. See Dr Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, Department of Health, JSCEOLC Transcript, 13 December 2017, Session 2 at 11 for a summary of the ethical principle and its application to medical practice.

121 See White and Willmott (2012) ‘How should Australia regulate voluntary euthanasia and assisted suicide?’ *Journal of Law and Medicine* 20, 410-438, and White, Willmott and Ashby (2011) ‘Palliative care, double effect and the law in Australia’ *Internal Medicine Journal* 41(6) 485-492, both provided by Prof Willmott and Prof White, Directors, Australian Centre for Health Law Research, and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, in JSCEOLC Submission 560.

122 White, Willmott and Ashby (2011) ‘Palliative care, double effect and the law in Australia,’ *Internal Medicine Journal* 41(6) 485-492 at 486-7.

123 *Ibid* at 487, citing DuBose and Berde (1997) ‘Respiratory effects of opioids’ *IASP News* at 3-5. The authors also refer to two clinical observational studies which show no evidence of shortened survival resulting from opioid or sedative use in the last days of life: Good, Ravenscroft, Cavenagh (2005) ‘Effects of opioids and sedatives on survival in an Australian inpatient palliative care population’ *Intern Med J* 39, 512-17 and Sykes and Thorns (2003) ‘Sedative use in the last week of life and the implications for end-of-life decision making’ *Arch Int Med* 163, 341-4.

supported by clinical practice evidence provided to the Committee by various medical practitioners and palliative care specialists.<sup>124</sup> In fact, in evidence to the Committee, high profile advocate of assisted suicide, Dr Phillip Nitschke, stated that morphine is an extremely variable drug in its effect on individuals and it is very difficult to provide someone with a lethal dose.<sup>125</sup>

- 1.90. Quality palliative care should not need to rely upon the medical ethical principle known as the doctrine of double effect as a justification for the administration of opioids or sedatives, as studies have shown that there is no association between the doses of opioids and sedatives on the last day of life and survival.<sup>126</sup> Emerging evidence shows that sedating medications, when used appropriately, do not hasten death and therefore the application of the doctrine of double effect does not come into play at all.<sup>127</sup> The conclusion of the 2009 Maltoni study was that 'Palliative sedation therapy does not

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124 See Dr Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, Department of Health, who states 'if you are using morphine appropriately to manage their symptoms, then the morphine is not what kills them,' in JSCEOLC Transcript, 13 December 2017, Session 2 at 12. See also Dr Parr, Director, Medical Services, St John of God Health Care and Palliative Medicine Consultant, who states 'if you are using medications in a skilled way, actually the evidence from the literature is that the doctrine of double effect does not really come into play, because what we are doing is titrating medication according to need, and then we are bringing about relief of symptoms and relief of distress, and dying may happen alongside that,' in JSCEOLC Transcript, 28 February 2018, Session 1 at 17; Prof Quinlan, Consultant General Physician, states 'It was very popular about 30 or 40 years ago to discuss the principle of double effect... I make it clear that it is not a legal principle; it is an ethical principle and, consequently, with better knowledge, better scientific knowledge, better experience, the day-to-day application of double effect is not commonly done,' in JSCEOLC Transcript, 1 March 2018, Session 4 at 4 and Dr Dunjey, General Practitioner, in answer to the question 'Do you think that medical practitioners rely on the doctrine of double effect when administering pain-relieving or sedating medications at the end of life?' stated 'The short answer is no. The question poses... a dilemma which... is not there and does not need to be there,' in JSCEOLC Transcript, 2 March 2018, Session 1 at 2; and Jane Phillips, President of Palliative Care Nurses Australia, who wrote 'To qualify the principle of double effect in everyday clinical practice, palliative care interventions based on evidence-based clinical practice guidelines and the individual characteristics of the patient and made by clinicians with appropriate qualifications and skills are highly unlikely to result in death. The most common foreseen but unintended effects of palliative care interventions are non-life threatening medication side effects, such as nausea, which is likely when a person first begins taking opioids for pain relief,' JSCEOLC Response to Questions on Notice, 29 January 2018 at 4; and Dr McNulty, Palliative Care Medical Specialist, Silver Chain, who stated 'We are very certain that the drugs we use do not hasten death, which is why we do not believe that we need the principle of double effect, because we are not doing anything to hasten death,' in JSCEOLC Transcript, 27 February 2018, Session 5 at 6.

125 Dr Nitschke, Exit International, JSCEOLC Transcript, 13 April 2018, Session 1 at 11.

126 Palliative Care WA, JSCEOLC Response to Questions on Notice, 19 December 2017 at 9.

127 See Dr Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, Department of Health, JSCEOLC Transcript, 13 December 2017, Session 2 at 19; Dr Best, Palliative Care Physician, JSCEOLC Transcript, 1 May 2018, Session 1 at 3-4.

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shorten life when used to relieve refractory symptoms and does not need the doctrine of double effect to justify its use from an ethical point of view.<sup>128</sup>

- 1.91. Dr Tandon put this most clearly in a written response to a series of question put to him by the Committee:

*At the outset, it must be reiterated once again that reference to the doctrine of double effect is erroneous and based on outdated medical knowledge and the incorrect interpretation of this information. An expanding evidence base has repeatedly confirmed that the appropriate use of sedating or pain-relieving medications does not hasten death. Peer-reviewed evidence has been provided to the Joint Select Committee to this effect. Having stated the above, in our opinion current law in Western Australia adequately protects doctors who act appropriately within the limits of their scope of clinical practice.<sup>129</sup>*

### **The morphine myth**

- 1.92. So why then do proponents continue to refer to the doctrine of double effect? For example, Professor White, in his evidence to the Committee, stated:

*We would say—and I expect you have heard this evidence before—in conversations with some medical colleagues, they say that it need not hasten death, but there are other medical colleagues who have reached the view that in some instances where a patient is close to death there is a prospect of that happening. There are, I guess, different views clinically on it. A relevant consideration from our perspective, putting aside whether or not it does in fact hasten death, is whether a perception that it does can exist.<sup>130</sup>*

- 1.93. The ‘morphine myth,’ that palliative sedation hastens death, is perpetuated by euthanasia proponents to draw an equivalence between palliative sedation and assisted suicide—that there is essentially no difference between a doctor relieving the patient’s suffering through sedation, which may also have the unintended consequence of hastening death, and the actions of a doctor who relieves a patient’s suffering through

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128 Maltoni et al (2009) ‘Palliative sedation therapy does not hasten death: results from a prospective multicenter study’ *Annals of Oncology* 20(7) 1163-1169, cited by Dr Anil Tandon, Chairman, WA Palliative Medicine Specialists Group, Supplementary Information Provided to the Committee.

129 Dr Tandon, Chairman, WA Palliative Medicine Specialists Group, JSCEOLC Response to Questions on Notice, 29 April 2018 at 1.

130 Prof White, Director, Australian Centre for Health Law Research, JSCEOLC Transcript, 26 February 2018, Session 2 at 3.

the administration of a lethal medication with the intent to cause the death of that patient.

- 1.94. The Committee received evidence from palliative care specialists that the myth exists both among the general public, and among medical practitioners. Dr Bradley said:

*I get that every single day at work. The families go, "Oh, you're going to set up the pump." It is kind of done in inverted commas, almost, as if they assume that because we are talking about providing appropriate levels of pain relief for the patient, sedation if they need it, that that is us as doctors ending their life. We spend a lot of our time on a day-to-day basis explaining that that is not at all what we are doing, that we are not hastening death.<sup>131</sup>*

- 1.95. Professor Forbes also held a similar view:

*I absolutely agree with you that the public does have a misperception here. I actually think it is a very dangerous misperception because it devalues life. It devalues the relationship with the physician as healer. If we lose that, we find it very difficult to do our work. Every therapeutic complication will end up being adjudicated by lawyers and destroy the medical system as we know it, let alone the relationship between patients and doctors.<sup>132</sup>*

- 1.96. In their own personal views, both Dr Bradley and Professor Forbes agreed that the morphine myth is a view also held by some medical practitioners.<sup>133</sup>

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131 Dr Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, Department of Health, JSCEOLC Transcript, 18 May 2018, Session 2 at 20-21. See also the comments made by Dr Best, Palliative Care Physician and Academic, with regard to subcutaneous injections of palliative medications, morphine and otherwise, and the perceptions of family members and others who witness it – 'It is just human nature. You see an injection, someone stops breathing. It is understandable that someone might think that they were connected, but most of the drugs we would use at the very end of life with someone whose body was slowing down, generally I think it would be very surprising if they had time to actually take effect, because at the end of life in palliative care we put a little needle under the skin. We do not put it straight into the vein because just under the skin, a subcut needle, is much more comfortable for the patient. It takes a longer time for those drugs to absorb. I think it is a visual thing that I understand people deciding, but in fact it is very unlikely that a subcut injection would cause an immediate stopping of breathing,' JSCEOLC Transcript, Session 2, 1 May 2018 at 9.

132 Prof Forbes, Acting Chief Medical Officer, Department of Health, JSCEOLC Transcript, 18 May 2018, Session 2 at 21.

133 Avant Mutual confirm that this is the case in some instances, noting that 'some practitioners express concern about providing increasing pain relief and sedation in the terminal phase of illness because of the concern that they may be subject to prosecution. The doctrine of double effect is often not well understood,' Avant Mutual, JSCEOLC Submission 545 at 2.

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- 1.97. In fact, the morphine myth and the doctrine of double effect may even act as a deterrent to the provision of good symptom control.<sup>134</sup> Some physicians may withhold pain medication because of ungrounded concerns that higher doses may accelerate death through respiratory suppression, or that the patient may become addicted to the medication:<sup>135</sup>

*Although a review of the medical literature reveals that the risk of respiratory depression from opioid analgesic is more myth than fact and that there is little evidence that the use of medication to control pain hastens death, the belief in the double effect of pain medication remains widespread. Applying the principle of double effect to end-of-life issues perpetuates this myth and results in the under-treatment of physical suffering at the end of life.*<sup>136</sup>

- 1.98. The morphine myth, and a misunderstanding of the application of the doctrine of double effect in palliative sedation, has also led some doctors to erroneously admit to intentionally hastening their patients' deaths, as Dr Tandon explains:

*It is widely recognised that in many cases doctors who admit to intentionally hastening their patients' deaths have misunderstood the application of the principle of double effect and the legislative framework within which they practice. As has been documented even in Australia, some medical practitioners equate the use of appropriate doses of morphine at the end of life with euthanasia, because they mistakenly think that morphine hastens death. As we have already seen, this is not the case. The Committee makes reference to studies that suggest some doctors already admit to intentionally hastening death even though it is currently against the law. We believe that most times this is a misunderstanding of the use of opioids and sedating*

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134 Sykes and Thorn (2003) 'The use of opioids and sedatives at the end of life' *The Lancet Oncology* 4(5) 312-318, cited by Dr Tandon in Supplementary Information provided to the Committee; Dr Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, Department of Health, also confirmed that she had seen underdosing or undermanaging of pain due to misconceptions held about sedatives in medical practice outside of palliative care: JSCEOLC Transcript, 18 May 2018, Session 2 at 21.

135 Snyder, Sulmasy and Mueller (2017) 'Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper,' Professionalism and Human Rights Committee of the American College of Physicians, *Annals of Int Med* 167(8) 576. See also Janet Hardy (2000) 'Sedation in terminally ill patients' Letter, *The Lancet*, 356 (9245) 1886-7, cited in Go Gentle Australia JSCEOLC Submission 539 at 29.

136 Fohr SA (1998) 'The double effect of pain medication: separating myth from reality' *J Palliat Med* 1(4) 315-28, cited by Dr Tandon, Chairman, WA Palliative Medicine Specialists Group, JSCEOLC Supplementary Information; See also Dr Best's comment that 'The morphine myth has been around for years, and we do not seem to be able to squash it. That is a shame because it makes people scared to use what is really an excellent treatment for pain,' Dr Best, Palliative Care Physician and Academic, JSCEOLC Transcript, 1 May 2018, Session 2 at 1.

*medication. However, it does indicate that some doctors are prepared to act outside the law. If this is the case, then we question how will changing the law make vulnerable people safer?*<sup>137</sup>

- 1.99. If the morphine myth and confusion or fear around the application of the doctrine of double effect is leading to poor management of patient symptoms, it does not follow that assisted suicide must be introduced.

*Under-dosing is a widely recognised problem and leads to much unnecessary suffering and distress for patients and their loved ones. In our opinion, under-dosing occurs not because of uncertainty regarding the law but because of a lack of medical training and erroneous, outdated teaching. Under-dosing is not because of an incorrectly used ethical principle but because of inadequate knowledge on the part of the doctor.*<sup>138</sup>

- 1.100. What is required is greater communication between specialist palliative care services and community level expertise. Specialist services frequently provide advice to general practitioners and others who provide palliative care about dosing, adjustments, safety and drug interactions.<sup>139</sup> Under-dosing is not a failure of palliative care—it is bad palliative care. It is the improvement of palliative care that must be a priority for the Government of Western Australia, and not the legalisation of assisted suicide.

#### **Finding 9**

Palliative sedation, when competently administered, is a legal and ethical end of life choice currently available in Western Australia.

#### **Finding 10**

An expanding evidence base has repeatedly confirmed that the appropriate use of sedating or pain-relieving medications does not hasten death.

#### **Finding 11**

Palliative sedation does not hasten death.

#### **Finding 12**

Under-dosing and failure to make a specialist referral are problems that lead to unnecessary suffering and distress for patients and loved ones.

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137 Dr Tandon, Chairman, WA Palliative Medicine Specialists Group, JSCEOLC Response to Questions on Notice, 29 April 2018 at 4.

138 Ibid at 2.

139 Prof Forbes, Acting Chief Medical Officer, Department of Health, JSCEOLC Transcript, 18 May 2018, Session 2 at 21.

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### **Finding 13**

Under-dosing and failure to make a specialist referral occur because of a lack of medical training and, in some cases, outdated teaching.

### **Recommendation 4**

The Minister for Health should facilitate and monitor an improved communication protocol, and if necessary an improved communication pathway, between medical practitioners and specialist palliative care services.

### **Recommendation 5**

The Minister for Health should develop and roll out a community awareness program about specialist palliative care services.

### **Recommendation 6**

The Minister for Health should consult with palliative care specialists about mechanisms to improve the training and continuous professional education of all health practitioners about specialist palliative care services.

## **Suicide and the Distinction between Palliative Care and Assisted Suicide**

- 1.101. While the final end of life choice, of suicide, is a choice available to Western Australians due to their inherent liberty, it is not a choice encouraged or promoted by the State. Indeed suicide prevention policies and programs have enjoyed long-standing bi-partisan support in Western Australia. Consequently, proponents of assisted suicide are regularly left needing to distance suicide from assisted suicide.
- 1.102. The suggestion is made by assisted suicide proponents that voluntary euthanasia and physician-assisted suicide sit on the spectrum of end-of-life care, alongside palliative care, advanced care directives and the refusal and withdrawal of treatment.<sup>140</sup> However, the choices available to Western Australians at end of life, including palliative care therapies, and the refusal of nutrition and hydration, refusal of medical treatment and palliative sedation have a number of things in common which make them distinct from assisted suicide.
- 1.103. Whilst palliative care is not curative, it also does not have the aim of ending a patient's life. Nothing undertaken in palliative care therapies is undertaken to hasten death.<sup>141</sup>

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140 Mr Denton, Go Gentle Australia, JSCEOLC Response to Questions on Notice, 13 May 2018 at 8.

141 Prof Evans, Chief Advisor, Public Policy, Silver Chain Group, JSCEOLC Transcript, 14 December 2017, Session 3 at 14.



The cause of death of each of these treatment choices will continue to be the underlying disease or condition suffered by the patient.<sup>142</sup>

- 1.104. Assisted suicide, on the other hand, intends to shorten life and death is caused by the administration of lethal medications, and therefore should remain distinct from the field of palliative care.<sup>143</sup> The European Association for Palliative Care defines euthanasia as ‘a physician (or other person) intentionally killing a person by the administration of drugs, at that person’s voluntary and competent request,’ and defines physician-assisted suicide as ‘a physician intentionally helping a person to terminate their life by providing drugs for self-administration, at that person’s voluntary and competent request’.<sup>144</sup>
- 1.105. Proponents and opponents alike agree that the suffering of the patient must be relieved, but disagree on the means by which to achieve this goal. Those opposed to assisted suicide hold the view that killing the patient is not a supportable means to reach the desired goal of relieving suffering. Rather, they suggest that ‘we must kill the pain and suffering, not the person with the pain and suffering.’<sup>145</sup>
- 1.106. A critical distinction between assisted suicide and the palliative care choices available to Western Australians at end of life is that the current choices available to patients are all reversible. Palliative care, refusal of hydration and nutrition, refusal of medical treatment and palliative sedation are all reversible. If the intention is to cause the death of the patient, as it is in voluntary euthanasia and physician-assisted suicide, the process kills the patient.<sup>146</sup>
- 1.107. What the above discussion about current end of life choices available to Western Australians reveals is that assisted suicide is not a step on the continuum of good end-of-life practices, as it is radically different as the intent is no longer to care but to kill.

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142 Mr Cockayne, General Manager, Health Care WA, Silver Chain Group, JSCEOLC Transcript, 14 December 2017, Session 3 at 16.

143 Dr Tandon, Chairman, WA Palliative Medicine Specialists Group, JSCEOLC Response to Questions on Notice, 29 April 2018 at 4.

144 Radbruch L et al (2015) ‘Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care’ *Palliative Medicine* <<http://www.eapcnet.eu/LinkClick.aspx?fileticket=28Vb6OIn9SQ%3D>> quoted in Palliative Care Nurses Australia, Jane Phillips, President, JSCEOLC Answers to Questions on Notice, 29 January 2018 at 7.

145 Sprung et al (2018) ‘Physician-Assisted Suicide and Euthanasia: Emerging Issues from a Global Perspective’ *Journal of Palliative Care* [sagepub.com/journalsPermissions.nav](http://sagepub.com/journalsPermissions.nav) DOI: 10.1177/0825859718777325 at 4.

146 Dr Dunjey, Convenor, Medicine With Morality, JSCEOLC Transcript, 2 March 2018, Session 1 at 3.

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### **Finding 14**

A critical distinction between assisted suicide and the palliative care choices available to Western Australians at end of life is that the current choices available to patients are all reversible.

## Chapter 2

### The Risks of Legalised Assisted Suicide— Casualties Guaranteed

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But the stakes go up when you are saying that someone is going to die.

Dr Nathan Gibson, Chief Psychiatrist of Western Australia, 14 December 2017

There is only one person left, usually, to tell what happened, and that is the person who is under investigation. That is a real problem... at the end of the day it is one person's say-so... The patient, of course, is deceased.

Miss Amanda Forrester, Director of Public Prosecutions (WA), 27 February 2018

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#### Autonomy, Self-Determination and Choice—The Basis of Calls for Assisted Suicide

- 2.1. Calls for the legalisation of assisted suicide in Western Australia, and elsewhere, are based on the social theories of independence and individualism, and values of autonomy, self-determination and choice. Calls for 'choice' were echoed in the submissions made to the Committee,<sup>147</sup> in evidence given to the Committee in public hearings,<sup>148</sup> and indeed among Committee members.<sup>149</sup>

However:

*Advocates of assisted death assume that it is possible to distinguish between euthanasia requests that are a mis-expression of an*

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147 For example, see Willmott and White (2017) 'Assisted Dying in Australia: A Values-based Model for Reform,' in *Tensions and Traumas in Health Law* submitted in Professors Willmott and White, Directors, Australian Centre for Health Law and Research and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, JSCEOLC Submission 560A; and Motor Neurone Disease Association (WA) (MNDAWA), JSCEOLC Response to Questions on Notice, undated at 9.

148 See comments made by Mr Teale, Chief Executive, Council on the Ageing (WA), JSCEOLC Transcript, 2 March 2018, Session 5 at 8 regarding the ability to make an 'informed choice' and the comments made by Mrs Trendall, Senior Citizen, JSEOLC Transcript, 7 March 2018, Session 1 at 3, that '[e]ach individual is an independent person and as long as their choice of an end does not in any way impose on any other person, I do not see that there need be any controversy.'

149 See Hon Dr Sally Talbot, Committee Member, JSCEOLC Transcript, 14 December 2017, Session 3 at 15, where the Honourable Member states 'I think the evidence that you have given us is very evocative in terms of emphasising the point about the choice of people who are dying. It seems to me, without wishing to put words into your mouth, that it may be that certain people choose to opt for voluntary assisted dying as one of their options as part of the ways of expanding their choice.'

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*underlying, unresolved need, and those that reflect a personal philosophy of choice, despite optimal care. The stakes are high. Interviewees gave examples of patients who had earlier demanded euthanasia but who then went on to find meaning through the natural dying process. Similarly, there were examples of patients who had contemplated suicide, or survived the attempt, but who valued the life they went on to live. The enemy, in the end, is a simplistic view.*<sup>150</sup>

- 2.2. In the words of Mr Dwight Randal, President of the Coalition for the Defence of Human Life:

*It is more than personal if it requires governments to revise laws to allow certain types of homicide and suicide. It is more than personal if it requires doctors to assist in the killing. It is more than personal if it desensitises medical staff to the preciousness of human life...It is more than personal if it creates an atmosphere in which other weak or unwanted people feel pressured to choose to die.*<sup>151</sup>

- 2.3. Archbishop Timothy Costelloe, Catholic Archbishop of Perth, also saw an important distinction between personal autonomy and absolute personal autonomy since we all exist as persons in society:

*We do not exist as completely isolated, autonomous people, whose decisions have no impact on anybody else. So I think our rights have to be balanced by our responsibilities to the society of which we are a part and to which we have certain obligations. We are not talking about a private and personal decision when we are talking about euthanasia or voluntary assisted dying; we are talking about a decision which, fundamentally, alters a foundational principle upon which our society has been built. So no matter how private the decision might be in one sense that a person might take to seek euthanasia or assisted dying, inevitably, because of the web of relationships that are part of being human, it has impacts beyond the person... and their family.*<sup>152</sup>

- 2.4. Mr Christopher Harkness also expressed his concern that ‘the debates in our culture about euthanasia take a populist and superficial stance that fails to consider the

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150 Magnusson RS (2002) *Angels of death: exploring the euthanasia underground* at 252.

151 Mr Randal, President, Coalition for the Defence of Human Life, Presentation to the Select Committee on End of Life Choices, included in JSCEOLC Response to Questions on Notice, 17 April 2018 at p8 – quoting Andrew Lansdown (2017) ‘If people were dogs and other false arguments for euthanasia,’ *Life Ministries*, 18 January 2017 <<http://www.lifeministries.org.au/pamphlets/if-people-were-dogs-and-other-false-arguments-for-euthanasia/>>

152 Archbishop Costelloe, Catholic Archbishop of Perth, JSCEOLC Transcript, 8 March 2018, Session 6 at 2-3.

implications for both the individual and society at large. The debate sometimes fails to progress beyond the notion of the rights of the individual to have a dignified death.<sup>153</sup>

- 2.5. In Chapter 2 of this Report, the discussion moves beyond the philosophical justifications for legalised assisted suicide around autonomy and self-determination and considers the practical realities of the revision of laws to allow for doctors to kill, or assist in the killing of their patients in certain circumstances. This Chapter seeks to address the following questions:
- 2.6. How do we assess whether an individual is competent to make the autonomous choice of assisted suicide? And, how do we determine that an individual's request for assisted suicide is not affected by demoralisation?
- How do we ascertain whether an individual's consent is informed and voluntary?
  - Does assisted suicide present an issue for disability discrimination?
  - Does assisted suicide conflict with suicide prevention programs already in operation in Western Australia?
  - Is the medical professional best placed to implement assisted suicide laws?
  - Does legalised euthanasia actually guarantee a good death?

#### **Finding 15**

Calls for the legalisation of assisted suicide are based on social theories of independence and individualism and values of autonomy, self-determination and choice.

#### **Finding 16**

There is a distinction between personal autonomy and absolute personal autonomy.

### **Assessment of Competency**

- 2.7. Willmott and White's recommendation that 'assisted dying' be permitted is underpinned by the value of autonomy, though they recognise that a person must be competent to exercise that autonomous choice.<sup>154</sup> Determining whether a patient is competent to exercise the choice of assisted suicide then becomes central.

#### **Optional referral for psychiatric assessment**

- 2.8. Proponents of assisted suicide assert that the consulting doctor is capable of assessing patient competence, and that psychiatric consultation is only needed when either of the assessing doctor is uncertain about the patient's competence or mental state. A

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153 Christopher Harkness, JSCEOLC Submission 266 at 3.

154 Willmott and White (2017) 'Assisted Dying in Australia: A Values-based Model for Reform' in *Tensions and Traumas in Health Law* at 501, provided in Profs Willmott and White, Directors, Australian Centre for Health Law Research, and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, JSCEOLC Submission 560A.

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mandated psychiatric assessment is said to belittle the individual's autonomy, and mandating psychiatric assessment would limit access to assisted suicide since access to psychiatric opinion is limited.<sup>155</sup> General practitioners are considered best placed to assess the patient's mental state and decision making capacity, due to their longitudinal relationship with the patient and the routine use of this assessment in all health care decisions that patients make.<sup>156</sup> This view presupposes that a decision on assisted suicide is comparable to all other health care decisions.

- 2.9. In the Go Gentle Australia submission to the Committee, Mr Denton notes '[w]hat is essential for the purpose of assessing a patient's eligibility for physician assisted dying is not so much 'depression' as the presence of 'adequate decision-making capacity'. There are specific criteria and guidelines for making this kind of assessment and doctors (not just psychiatrists and psychologists) are competent to make these kinds of judgments.'<sup>157</sup> In support of this statement, Mr Denton cites Joshua M. Baruth and Maria I Lapid, 'Influence of Psychiatric Symptoms on Decisional Capacity in Treatment Refusal.'<sup>158</sup>
- 2.10. A closer reading and examination of this article shows that while Mr Denton correctly recites that there are 'specific criteria and guidelines' for assessing capacity (the authors refer to the MacArthur Competence Assessment Tool for Treatment (MacCAT-T) as one instrument to assist clinicians in evaluating decisional capacity), the authors also state:

*Importantly, it has been shown that physicians often fail to correctly recognise incapacity, sometimes as much as 58 per cent of the times, which further highlights the importance of using formal assessments like the MacCAT-T as well as consulting relatives and other members of the health care team.*<sup>159</sup>

- 2.11. And further:

*Additionally, the impact of a decision should be considered. For example, vastly different outcomes result from refusing a life saving treatment that could result in death and refusing a low-risk treatment*

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155 Doctors for Assisted Dying Choice, JSCEOLC Submission 402 at 4.

156 Ibid at 11. See also Mr Perron, Private Citizen, JSCEOLC Transcript, 13 April 2018, Session 2 at 2; Mr Walker, Vice President, Dying with Dignity WA, JSCEOLC Transcript, 13 April 2018, Session 5 at 5; Dr Hennessy, Head of Anaesthesia Department, Sir Charles Gairdner Hospital, JSCEOLC Transcript, 30 April 2018, Session 1 at 11; Prof Willmott, Director, Australian Centre for Health Law Research, JSCEOLC Transcript, 26 February 2018, Session 2 at 19; Dying With Dignity (WA), JSCEOLC Submission 565 at 23; Prof Kamien, Medical Practitioner/Emeritus Professor of General Practice, UWA; Doctors for Assisted Dying Choice, JSCEOLC Transcript, 2 March 2018, Session 3 at 10-11.

157 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 6. Part E 41.

158 Baruth and Lapid (2017) 'Influence of Psychiatric Symptoms on Decisional Capacity in Treatment Refusal,' *AMA Journal of Ethics* 19(5) 416-425.

159 Baruth and Lapid (2017) at 420.

*that may or may not have negative consequences. Accordingly, with decisions involving greater risk, a physician should consider more than a single, objective assessment of capacity and incorporate more information based on prior decisions or what others consider a reasonable decision.*<sup>160</sup>

2.12. The authors conclude:

*It is not appropriate to let a prior or current psychiatric diagnosis solely determine decisional capacity. However, if a patient is currently suffering from a mood disorder, is potentially suicidal, or has any other condition that could potentially compromise his or her capacity, the patient should be referred to a psychiatrist for a formal consultation.*<sup>161</sup>

2.13. This closer reading of the Baruth article reveals that the assessment of capacity by doctors can be supported by assessment tools, but that the assessment of capacity is very complex, particularly in decisions involving greater risk to the patient. This inconvenient truth is not addressed by proponents.

2.14. The assurance given by those who do not see a need for mandatory psychiatric assessment is that if the doctor has any doubts about capacity or any other thing in a patient's request, they can then refer them for psychiatric examination.<sup>162</sup> This 'optional referral' model was adopted in the Victorian legislation, which provides for approved training for capacity assessment and specialist referral where a doctor is 'unable to determine whether the person has decision-making capacity in relation to voluntary assisted dying as required by the eligibility criteria, for example, due to a past or current mental illness of the person.' Mr Denton suggests that 'such legislation will improve the capacity to detect mental illness in the terminally ill. Clinicians will be more vigilant in determining if it is present and, if detected, patients will be referred for psychiatric assessment and, if appropriate, care.'<sup>163</sup>

2.15. However the actual evidence from those jurisdictions with optional referral for psychiatric assessment is very different to this optimistic opinion. What has happened in these jurisdictions is that gatekeeping medical practitioners very seldom refer and this results in persons with treatable clinical depression being wrongfully assisted to suicide.<sup>164</sup>

2.16. In Oregon, research by Ganzini found that '[a]mong terminally ill Oregonians who participated in our study and received a prescription for a lethal drug, one in six had

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<sup>160</sup> Ibid at 421 (emphasis added).

<sup>161</sup> Ibid at 421-2.

<sup>162</sup> Mr Denton, Go Gentle Australia, JSCEOLC Transcript, 13 April 2018, Session 6 at 12.

<sup>163</sup> Mr Denton, JSCEOLC Response to Questions on Notice, 13 May 2018 at 5.

<sup>164</sup> Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 4.

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clinical depression.<sup>165</sup> Depression is supposed to be screened for under Oregon's enabling legislation. However, in 2016 less than one in twenty five (3.75 per cent) who died under the Oregon law were referred by the prescribing doctor for a psychiatric evaluation before writing a script for a lethal substance.<sup>166</sup> As to the efficacy of a single psychiatric visit to assess capacity, another study by Ganzini found that out of 321 psychiatrists in Oregon, only 6 per cent were very confident that in a single evaluation they could adequately determine whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide.<sup>167</sup> In light of this, it would be improper to suggest or assert that the optional referral system in Oregon safeguards against the assisted suicide of patients whose capacity is impaired by depression or other mental health considerations.

- 2.17. A similar experience is also found in other jurisdictions with optional referral for psychiatric assessment. In the Netherlands the rates of psychiatric assessment before euthanasia plummeted from 25 per cent in 1998 to 0 per cent in 2010.<sup>168</sup> In Washington state, examination of Department of Health reports reveals that only 4 per cent of patients were referred for psychiatric evaluations.<sup>169</sup>
- 2.18. The optional referral model also presupposes a longitudinal relationship between general practitioner and patient. Doctors for Assisted Dying Choice suggest that general practitioners are considered best placed to assess the patient's mental state and decision making capacity due to their longitudinal relationship with the patient.<sup>170</sup> This assertion fails to take into account that a patient may seek assisted suicide from a doctor with

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165 Ganzini et al (2008) 'Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey,' *BMJ* 337:a1682, quoted by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 4-5.

166 Oregon Public Health Division (2017) *Oregon Death With Dignity Act: Data Summary 2016*, Table 1, 'Characteristics and end-of-life care of 1,127 DWDA patients who have died from ingesting a lethal dose of medication as of January 23, 2016 [sic = 2017], by year, Oregon, 1998-2016,' at 9 – cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 5.

167 Ganzini et al (1996) 'Attitudes of Oregon psychiatrists toward physician-assisted suicide,' *Am J of Psych* 153, 1469-75, cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 5.

168 Leiva RA (2010) 'Death, suffering and euthanasia,' *Canadian Family Physician* 56(6), 528-530, cited by Rev Dr Parkinson, Director, LJ Goody Bioethics Centre, JSCEOLC Submission 53 at 6.

169 Emanuel et al (2016) 'Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada and Europe,' *JAMA* 316(1), 79-90 at 86, citing Washington State Department of Health, *Death With Dignity Act Reports, 2009-2015*  
<<http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct>>

170 Doctors for Assisted Dying Choice, JSCEOLC Submission 402 at 11. See also Mr Marshall Perron, Private Citizen, JSCEOLC Transcript, 13 April 2018, Session 2 at 2; Mr Walker, Vice President, Dying with Dignity (WA), JSCEOLC Transcript, 13 April 2018, Session 5 at 5; Dr Hennessy, Head of Anaesthesia Department, Sir Charles Gairdner Hospital, JSCEOLC Transcript, 30 April 2018, Session 1 at 11; Prof Willmott, Director, Australian Centre for Health Law Research, JSCEOLC Transcript, 26 February 2018, Session 2 at 19; Dying With Dignity (WA), JSCEOLC Submission 565 at 23; Prof Kamien, Medical Practitioner/Emeritus Professor of General Practice, UWA, Doctors for Assisted Dying Choice, JSCEOLC Transcript, 2 March 2018, Session 3 at 10-11.



whom they do not have a longitudinal relationship, nor is it likely that both assessing doctors will hold a longitudinal relationship with the patient.

- 2.19. The risks of not requiring a psychiatric capacity assessment were identified in a Committee hearing, in discussion between Hon Nick Goiran MLC and Dr Roger Paterson, Doctors for Assisted Dying Choice:

*Hon NICK GOIRAN: Are there any risks of not requiring a psychiatric capacity assessment?*

*Dr PATERSON: There is a theoretical risk. Dr Lisa Miller gave a very good account in her submission to the inquiry of a case where on a superficial level one could take the patient's wish for an early death at face value, but on further exploration and expert treatment that wish turned out to be not needed, fortunately. So you may argue that on occasion a psychiatric opinion may be necessary. We would certainly propose that that should happen, but not mandatory; really leave it up to the GPs who are best placed to make that assessment or referral on when necessary. The GPs know the patients over many, many years in many situations. A psychiatrist coming in cold, as it were, would have to start again. GPs are really well placed to make an assessment of cognitive capacity and psychiatric capacity, and if they are suspicious of any impairment they would refer on. I think psychiatrists would be able and willing to get involved at that stage.*

*Hon NICK GOIRAN: It is an interesting point. In that Miller case you referred to, wasn't the problem that it was not picked up early and it was not until the expert was involved that there was able to be the right treatment provided? So if the GP misses it at first instance and there is not a mandatory requirement to go to a psychiatrist, the opportunity is lost?*

*Dr PATERSON: Yes. As I say, it is a theoretical problem—in this case a very real practical problem; an actual problem.*

*Hon NICK GOIRAN: It was an actual problem in the Miller case.*

*Dr PATERSON: You could be extra, extra, extra careful and insist on a psychiatrist getting involved, but no jurisdiction has that around the world and I can see why; it just would not work.<sup>171</sup>*

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<sup>171</sup> Dr Paterson, Doctors for Assisted Dying Choice, JSCEOLC Transcript, 26 February 2018, Session 4 at 9-10.

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### Mandatory psychiatric assessment

- 2.20. With regard to the assessment of ‘the potential existence of mental illness in an end of life decision’, Dr Nathan Gibson, Chief Psychiatrist of Western Australia, recommends ‘that any assessment:’

- a. Be mandatory*
- b. Be multiphasic*
- c. Be undertaken over a period of time*
- d. Require extensive third-party corroboration*
- e. Be subject to assessment by multiple credentialed practitioners in any single, individual case*
- f. Be vetted, to exclude inadequate treatment, support or carer resourcing<sup>172</sup>*

- 2.21. Dr Gibson advised that a psychiatrist should provide the clinical assessment of capacity for assisted suicide. The analogy drawn by the Chief Psychiatrist is that, under the *Mental Health Act 2014* (WA), for an individual to be made involuntary he or she must be seen by a psychiatrist. The consequence of holding that person involuntarily is considered so serious that they must be seen by a psychiatrist to determine capacity. Dr Gibson states ‘What I would not like to see is a watered down version that would not apply the same rigour to individuals seeking to end their life.’<sup>173</sup>

- 2.22. With regard to the assessment of a patient’s capacity by a general practitioner, Dr Gibson goes on to state:

*In the situation where a GP is treating mental illness, assisting with the palliative care and making potential capacity assessments that are not leading to the potential death of the person, that may be reasonable. But the stakes go up when you are saying that someone is going to die. I do not think it is reasonable to have a GP make that capacity assessment at that point.*<sup>174</sup>

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172 Dr Gibson, Chief Psychiatrist of Western Australia, JSCEOLC Submission 655 at 4-5.

173 Dr Gibson, Chief Psychiatrist of Western Australia, JSCEOLC Transcript, 14 December 2017, Session 5 at 12. Dr Gibson also restated this position in a later Committee hearing, see JSCEOLC Transcript, 28 February 2018, Session 3 at 3.

174 Dr Gibson, Chief Psychiatrist of Western Australia, JSCEOLC Transcript, 14 December 2017, Session 5 at 13 (emphasis added).

- 2.23. Dr Gibson recognises that he errs on the side of caution in recommending mandatory assessment, but explains his position in this way:

*I plump on the side that we are better to take a rigorous approach and ensure that we do not miss out on those individuals who may have difficult and challenging presentations of mental illness so that those individuals are absolutely able to access the treatment and care that they need. There are logistic issues, I understand, but I am not sure that it would necessarily significantly delay the process for individuals who had capacity who were seeking to access legislation. So, I am really looking at a “first do no harm” to that cohort that really need that assessment. Whether you plump on a psychiatrist or a medical practitioner, if you plump on the side of a medical practitioner, there may be some situations in which someone has a mental illness that is not picked up and not treated, so there may be some cases there. It depends where you actually put the weighting, and I am weighting on the side of a more cautious approach. As I said, I do not think I am out of step with many of my colleagues in that regard. I think there is a multitude of different views. I guess I am trying to make a case for the protection of individuals with mental illness, access to treatment for individuals with mental illness and that in the whole picture there are the rights of people seeking, if the legislation comes in, voluntary assisted dying. There are also the rights of people who may be unwell who need the rigour of assessment.*<sup>175</sup>

- 2.24. When we consider the complexities involved in assessment of capacity (below), it is clear that Dr Gibson’s caution is not misplaced.
- 2.25. It should also be noted that while the WA branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) expressed concern about resourcing and access issues associated with mandatory psychiatric assessment, the WA branch did not go so far as the RANZCP Victorian branch who gave evidence to the Victorian Inquiry that optional referral for psychiatric assessment was preferable. The WA branch considered specialist capacity assessment by other specialists, for instance, palliative care specialists and geriatricians, to be of significance. They note that ‘[f]or such a difficult area... most medical practitioners would want to seek a specialist capacity assessment... Around end of life choices, obviously, there would have to be a degree of scrutiny of that because it is such a difficult and permanent decision.’<sup>176</sup> RANZCP(WA) did not defer capacity

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175 Dr Gibson, Chief Psychiatrist of Western Australia, JSCEOLC Transcript, 28 February 2018, Session 3 at 8 (emphasis added).

176 Dr Moore, Branch Chair, Royal Australian and New Zealand College of Psychiatrists (WA), JCEOLC Transcript, 28 February 2018, Session 5 at 3 and 4.

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assessment to general practitioners and still saw specialist assessment to be of importance.

- 2.26. Further in their submission, RANZCP(WA) state 'Given the serious medico-legal implications, [assessments of mental health diagnoses or cognitive impairment] are necessarily detailed and often require collection of extensive background history, liaison with family/carers and health professionals.' RANZCP(WA) suggest that 'due to the often rapidly changing manifestations of mental illness, proper assessments are best undertaken by clinicians with the benefit of extended interactions over a significant period of time with the individual in question.'<sup>177</sup> They also note that '[t]raumatic brain injury, addictions, dementia and delirium may all confound assessments of capacity and non-psychiatrically trained doctors "are not well placed to recognise the presence of these conditions in the medically ill population."<sup>178</sup>

### **The complexities involved in the assessment of capacity**

- 2.27. The reasons behind a preference for specialist assessment of capacity are various and relate to the complexity involved in assessing a patient's capacity, particularly in the context of assisted suicide.
- 2.28. Dr Gibson notes that:

*While individuals with mental illness must be afforded the same rights as other individuals within society, they are implicitly vulnerable in the potential context of seeking end of life because of issues of stigma, the inherent nature of mental illness (the complexity of determining remedial drivers and the influences on these), and the complexity of determining capacity.*

*It is inherently complex to determine the influences on drivers to seek end of life in an individual with mental illness.*

*It cannot be assumed that decision making regarding end of life for an individual with mental illness is linear, simple or obvious.<sup>179</sup>*

- 2.29. In his submission to the Committee, the Chief Psychiatrist identifies a number of factors that contribute to the complexity of assessing capacity:
- Capacity is decision specific
  - Capacity is fluctuant, and can change over time

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177 Royal Australian and New Zealand College of Psychiatrists (WA), JSCEOLC Submission 391 at 6.

178 Ibid, quoting Ryan C (2012) 'Playing the Ferryman: Psychiatry's role in end-of-life decision-making,' *ANZJ of Psych* 46(10) at 932-5.

179 Dr Gibson, Chief Psychiatrist of Western Australia, Submission 655 at 4 (emphasis added).

- The assessment of capacity in a clinical setting cannot be a ‘tick-box,’ but involves a robust interpersonal assessment as well as consideration of the specific criteria
- Ability to assess capacity is a variable skill across medical practitioners
- Where an individual has significant, fluctuating mental illness, the clarification of decision-making capacity can be a significant ongoing challenge; Capacity is complex in individuals with mental illness<sup>180</sup>

2.30. Dr Gibson also testified to the difficulty of assessing capacity, and that someone who *appears* to have capacity may actually be lacking capacity:

*The example of that [where someone lacks capacity or the psychiatrist has uncertainty about the individual's capacity] is where you see someone - it is not an uncommon scenario—and they appear to have capacity. But when you go and speak to their family, it is very clear that what they have said to you is entirely problematic and they do not have capacity, based on what they have been doing. What they have been saying does not reflect what they have been doing. Sometimes if you just do a one-off assessment with the person, you could be tricked, not because the person is trying to trick you; you just do not get the full story. That is why I think if there is any doubt, you should do it again. Certainly, if someone does not have capacity, you should do it again as well.*<sup>181</sup>

2.31. RANZCP(WA) also note that:

*People suffering from mental disorders may manifest significant fluctuations in their cognitive function over short periods of time and may also vary in decision-making capacity depending on the matter being addressed... For a person with co-existing physical and mental illnesses, ensuring adequate decision-making capacity in the context of PAS may therefore pose significant challenges.*<sup>182</sup>

2.32. The issue of co-morbidity as a complicating factor in the assessment of capacity has also been raised in peer-reviewed literature. Ryan, a Consultation-Liaison Psychiatrist from the Department of Psychiatry, Westmead, notes that ‘Sadness and despair are normal

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180 Ibid at 3-4 (emphasis added). That capacity assessment is a difficult area medically, since capacity can fluctuate and change, was also acknowledged by Mrs Wallace, Delegate of Justice Jeremy Curthoys, State Administrative Tribunal of WA, JSCEOLC Transcript, 28 February 2018, Session 6 at 5-6.

181 Dr Gibson, Chief Psychiatrist of Western Australia, JSCEOLC Transcript, 14 December 2017, Session 5 at 15.

182 Royal Australian and New Zealand College of Psychiatrists (WA), JSCEOLC Submission 391 at 6 (emphasis added).

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responses to the news that one is gravely ill. However, as many as one in five seriously ill people go beyond this normal response to develop major depression. Major depression is far more than a disorder of emotion; its effects on reason and the intellect may be just as profound.<sup>183</sup> Further:

*Unfortunately, the diagnosis of major depression in the gravely ill is very difficult. Low spirits are to be expected in serious illness, and many of the other features of major depression (such as weight loss and sleep disturbance) are also common in physical illnesses. The difficulty of diagnosis is reflected in studies that reveal that non-psychiatrically trained doctors miss up to half of cases of major depression in the medically ill.*<sup>184</sup>

- 2.33. The risk of undiagnosed mental illness was also identified by the New York Task Force on Life and the Law in a 1997 supplementary report:

*Many individuals who contemplate suicide — including those who are terminally ill — suffer from treatable mental disorders, most commonly clinical depression. Yet, physicians routinely fail to diagnose and treat these disorders, particularly among patients at the end of life. As such, if assisted suicide is legalised, many requests based on mental illness are likely to be granted, even though they do not reflect a competent, settled decision to die.*<sup>185</sup>

- 2.34. The difficulties faced by patients with co-morbidity was also addressed in evidence given to the Committee. Dr Best noted that the incidence of depression is high in terminally ill patients, and up to 80 per cent of depressed patients with cancer are not diagnosed or treated.<sup>186</sup> Dr Khorshid of the AMA(WA) noted that:

*[T]he discussion around diagnosis of depression and other mental illnesses that are co- morbid with terminal illnesses is very difficult for the average doctor and very difficult for a palliative care physician or any non-psychiatrist, and, in fact, is probably difficult for psychiatrists as well. Our strong recommendation is that a psychiatric assessment be completed for everybody accessing this option, partly around*

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183 Ryan CJ (1996) 'Depression, decisions and the desire to die' *Med J Aus* (1996) 165(8) at 411.

184 Ibid (emphasis added) – citing the following studies: Feldman, Mayou and Hawton et al. (1987) 'Psychiatric disorder in medical patients,' *QJM* 63, 405-412; Nielson and Williams (1980) 'Depression in ambulatory medical patients: Prevalence by self-report questionnaire and recognition by nonpsychiatric physicians' *Arch Gen Psychiatry* 37, 999-1004 and Clarke and Smith (1995) 'Consultation-liaison psychiatry in general medical units,' *Aust NZ J Psych* 29, 424-432.

185 New York Task Force on Life and the Law (1997) *Supplementary Report to When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context (1994)* at 4-5; quoted by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 10.

186 Dr Best, Palliative Care Physician and Academic, JSCEOLC Transcript, 1 May 2018, Session 2 at 3.

*competence...but mainly to exclude significant mental illness. We know those rates of mental illness are extremely high in this population and we would not countenance access to euthanasia because someone is depressed. We feel that would be an inhumane treatment.*<sup>187</sup>

- 2.35. General data around liaison psychiatry suggests that around 40 per cent of people in a general hospital setting may be experiencing some degree of significant mental health comorbidity along with their physical health morbidity. Comorbid depression with cancer or other advanced illnesses is common.<sup>188</sup>
- 2.36. The impact of failure to identify psychiatric comorbidity in terminal patients is illustrated in a Palliative Care Australia article in which Professor Gregory Crawford shares the difficulty he has encountered in identifying psychiatric illness in a patient suffering from a terminal condition:

*One of the motivators was that I looked after a 15-year-old girl who had a malignancy who looked like she was dying. I was working as the clinical head of palliative care at a hospital in Adelaide, and she was referred to us on the basis that she only had weeks to live. She had difficult pain to manage and other symptoms that led to her becoming more and more withdrawn.*

*I was slow to recognise that she was depressed and I found it hard to find advice and support about to manage it.*

*I looked in the literature and talked to psychiatrists and other colleagues. I ended up changing her antidepressants and she made a miraculous improvement, both physically and psychologically. She improved and lived for another 12 months. She had serious, progressive disease but her physical function and her ability to interact and live improved. She went off on a holiday, achieved some other things on her wish list and made lots of other nice memories for her family.*

*She died at home, supported by our palliative care service and her GP, and we had support from the paediatric palliative care service.*

*It showed me that sometimes the symptoms of impending death and the symptoms of advanced depression can look very much the same. I felt a bit like I had failed, having taken so long to recognise her depression and then act on it, which made me determined to learn more*

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187 Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 18 May 2018, Session 1 at 7.

188 Dr Miller, Clinician, Consultant Liaison Psychiatrist in Cancer and Palliative Care, JSCEOLC Transcript, 13 December 2017, Session 4 at 4-5.

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*about depression in this context. It drove me to try and understand more about psychological illness.*

*There has been a large amount of research in this area, but it is still very difficult to really determine what is a normal reaction to what is happening, like sadness, and what is an abnormal reaction, like a major depressive illness.*

...

*The implications of not diagnosing are that patients have increasing suffering and may not be getting the best treatment. They may be losing an opportunity to have more time or meaningful interaction with people around them. For their families, this can be a very large trauma; to not understand why somebody has turned their back on them or why they might be rejecting relationships, being overwhelmingly sad, or wanting to die precipitously. When triggered by depression, those responses can be quite challenging.<sup>189</sup>*

- 2.37. Professor Crawford notes that the implications of not diagnosing a mental illness in a terminal patient are that the patient will have increased suffering and may not be receiving the best treatment. Were assisted suicide to be legalised in Western Australia, the implications for the patient would also include an early and unnatural death.

### **Demoralisation and the wish to hasten death**

- 2.38. In any event, reducing the need for psychiatric consultation to the issue of competency ignores the relevance of other psychological factors that go into the request for assisted suicide.<sup>190</sup> RANZCP(WA) note in their submission that there is a significant body of literature around the wish to hasten death, which should be taken into account in any discussion of this important and complex area.<sup>191</sup>
- 2.39. RANZCP(WA) emphasise the need for better supported consultation-liaison psychiatry with psychiatrists who specialise in the treatment of mental illness in the context of physical illness:

*In situations where a patient has a terminal condition causing suffering, there is a risk that symptoms of mental ill health may be mistaken by a*

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189 Heather Wiseman (2017) 'Distinguishing between sadness and depression at the end of life: a significant challenge tackled by a leader in palliative care,' *Palliative Care WA*, 29 August 2017 – interview with Prof Gregory Crawford.

190 Golden and Zoanni (2010) 'Killing Us Softly: The Dangers of Legalizing Assisted Suicide,' *Disability and Health Journal* 3(1) 16-30 at 23-24, citing Hendin and Foley (2008) 'Physician assisted suicide: a medical perspective,' *Michigan Law Review* 106, 1613-1640.

191 Royal Australian and New Zealand College of Psychiatrists (WA), JSCEOLC Submission 391 at 2.



*doctor not trained in psychiatry for an 'understandable' reaction to their condition. Furthermore, treatment for mental health issues can help to relieve the experience of physical pain, due to the interaction of biological and psychological systems.*<sup>192</sup>

- 2.40. As cited earlier, advocates of assisted suicide assume that it is possible to distinguish between euthanasia requests that are a mis-expression of an underlying, unresolved need, and those that reflect a personal philosophy of choice, despite optimal care. The evidence given to the Committee with regard to the complexity of consultation-liaison psychiatry indicates otherwise.
- 2.41. Dr Lisa Miller, Clinician and Consultant Liaison Psychiatrist in Cancer and Palliative Care, gave evidence to the Committee that the expression of a wish for hastened death must be distinguished from specifically a desire to end life, or the desire to pursue assisted suicide as a mechanism of ending life.<sup>193</sup> The case study she presented clearly illustrates the risk assisted suicide represents for patients affected by a mental illness such as depression, but also the condition of demoralisation:

*I have a single clinic. It is the only specifically funded cancer liaison psychiatry clinic in Western Australia. It had a month waitlist, but the urgency of the situation meant that I made specific time to be able to see this fellow within two days of receiving that contact.*

*I then met with him and with his wife and he certainly appeared very low in mood. I asked him to tell me a bit more about his experience. He described his discomfort on swallowing. He had lost a substantial amount of weight, approximately 10 kilograms, over the course [of] his treatment. He felt that this was unendurable for him. He really felt that there was no point in continuing to live if life meant living like this.*

*So as a process of taking an individualised history from him, finding out a little bit more about him as a person, the things that were important to him, he was able to actually articulate that there was a range of physical symptoms that were contributing to his significant distress, particularly that pain was making it very difficult for him to eat. He felt that if continued treatment meant that he would continue to need to experience this burden, that that was clearly not an option for him. But he actually also was very much wanting to be helped at the same time,*

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<sup>192</sup> Ibid at 4.

<sup>193</sup> Dr Miller, Clinician, Consultant Liaison Psychiatrist in Cancer and Palliative Care, JSCEOLC Transcript, 13 December 2017, Session 4 at 2.

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*so I certainly did feel that he was suffering from a major depressive disorder.*

*I also felt that he was suffering, because I am a palliative medicine specialist by training as well, that he had severe mucositis—so inflammation of the very sensitive mucosal linings that can happen with chemo and radiotherapy for head and neck cancers—and that his substantial weight loss and the associated malnutrition that he had developed was also likely to be a feature contributing both to his low mood, his fatigue, and also to his inability to actually improve his nutrition. Once people slip into starvation syndrome, it is very difficult for them to restore their own nutrition. So in the process of speaking with him and with his wife, he was agreeable to me starting an antidepressant medication that I know to be tolerable for people who are undergoing cancer treatment. It comes in a particular soluble form that makes it less difficult for people who are having trouble swallowing.*

*We organised for some specialist palliative care input, but also I was able to talk to the radiation oncology registrar through optimising some of his medication so that he could tolerate those in a form that was manageable for him, as opposed to trying to swallow tablets.*

*In addition, I was able to organise a dietitian referral to work on some supplements to improve his diet. Ultimately, we actually did organise an inpatient hospital admission for some nasogastric feeding to improve his nutrition. Within two weeks, he was already exhibiting substantial improvement in his depression, his symptom control was better and he was feeling that he was sleeping better and, as a result, he was managing his emotions during the day a little better.*

*I was then able to follow him up and advocate on his behalf, on seeing him on a number of occasions over the next two months as he completed his treatment. Six weeks ago I saw him, big smile on his face, and he said, “Lisa, I’ve just been told my cancer is cured. I’m the best I’ve felt in 10 years. I know I still have a way to go in regaining some of my weight, but I’m back at work. I’m really looking forward to Christmas with my family.”*

*So, I bring this case because I think a nuanced assessment of an individual’s expression of their suffering that actually then drills down into the biological aspects of that, the psychological aspects of that, the social aspects of that, the spiritual aspects in terms of people’s sense of loss of meaning, loss of role functioning, loss of purpose et cetera, is*

*actually really crucial, both in terms of reducing their burden of suffering—I am a doctor and that is my role—but also very important for the experience of his family.*<sup>194</sup>

- 2.42. Dr Miller refers to the work of Monforte-Royo et al,<sup>195</sup> whose research suggests that an expressed wish to hasten death is generally a response to multidimensional suffering, and it is acknowledged as a phenomenon that tends to vary over time. It depends on the stage of circumstances in which an individual person might find themselves, and is reflective of a range of domains—physical, psychological, social, existential and spiritual. The wish for hastened death can hold different meanings for different individuals and it can serve functions other than to communicate a genuine wish to die. Dr Miller concludes that as such, there is a very important need to individualise the assessment and to hear the story of the person patient in order to understand what underpins that expression of that wish.<sup>196</sup>
- 2.43. Demoralisation as a diagnostic entity is an important consideration in the assisted suicide debate. It acknowledges that there are factors unique to each patient—outside of a diagnosis of clinical depression—that may influence a patient’s request for assisted death. For example, the Professionalism and Human Rights Committee of the American College of Physicians identify loneliness as having a mortality risk similar to that of smoking, yet the health implications of loneliness are underappreciated.<sup>197</sup>

In the case study offered by Dr Miller, the patient was diagnosed as suffering from depression, but was also demoralised:

*He was depressed and he was demoralised. I am sorry; I know that is a bit of a muddy distinction. He certainly met a full set of criteria for a major depressive episode, which is why I treated him with an antidepressant, which he responded very well to, but there were also features of demoralisation that related to the fact that he was having difficulty swallowing, could not sleep very well, had pain et cetera, and the sense of isolation that that created for him as well, so we were able*

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194 Dr Miller, JSCEOLC Transcript, 13 December 2017, Session 4 at 2-3.

195 Monforte Royo et al (2012) ‘What Lies Behind the Wish to Hasten Death? A Systematic Review and Meta-Ethnography from the Perspective of Patients’ *PLoS ONE* 7(5), e37117 doi:10.1371/journal.pone.0037117.

196 Dr Miller, Clinician, Consultant Liaison Psychiatrist in Cancer and Palliative Care, JSCEOLC Transcript, 13 December 2017, Session 4 at 2.

197 Snyder, Sulmasy and Mueller (2017) ‘Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper,’ Professionalism and Human Rights Committee of the American College of Physicians, *Annals of Int Med* 167(8) 576, citing Gerst-Emerson and Jayawardhana (2015) ‘Loneliness as a public health issue: the impact of loneliness on health care utilisation among older adults,’ *Am J Public Health* 105, 1013-9.

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*to actually address features so that both his demoralisation and his depression were responsive.*<sup>198</sup>

- 2.44. Access to consultation-liaison psychiatry in the context of legalised assisted suicide in this state would be of great concern. As Dr Miller noted in explaining her case study, she has the only specifically funded cancer liaison psychiatry clinic in Western Australia, and she has a month-long waitlist. St John of God Health Care also noted that rapid access to psychological and psychiatric services is limited outside the context of inpatient specialist palliative care. They note that in the absence of adequately addressing psychological distress, requests for assisted dying may be more likely.<sup>199</sup> Likewise, RANZCP(WA) state:

*Adequate support for consultation-liaison services is essential in ensuring people with chronic and terminal illnesses are able to alleviate or manage psychological suffering. It is arguable that patients are currently able to fully exercise choice regarding end of life care where such services are unavailable or poorly understood.*<sup>200</sup>

- 2.45. Monforte-Royo et al conclude that the results of their study into the wish to hasten death highlight the importance of analysing the meaning which patients in the advanced stages of an illness attribute to their suffering and its consequences, which renders them highly vulnerable.<sup>201</sup> The introduction of legalised assisted suicide in Western Australia would present an unacceptable risk to patients in an advanced stage of their illness whose wish for hastened death is not assessed and addressed by a specialised consultation-liaison psychiatrist, but is instead taken as a competent request for assisted suicide at face value.

### Finding 17

The stakes are high when an individual is given responsibility to distinguish between euthanasia requests that are a mis-expression of an underlying unresolved need, and those that reflect a personal philosophy of choice, despite optimal care.

### Finding 18

An assisted suicide regime with an optional referral for psychiatric capacity assessment does not safeguard against the assisted suicide of patients whose capacity is impaired by depression or other mental health considerations, in part because the ability to assess capacity is variable across medical practitioners.

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198 Dr Miller, Clinician, Consultant Liaison Psychiatrist in Cancer and Palliative Care, JSCEOLC Transcript, 13 December 2017, Session 4 at 5.

199 St John of God Health Care, JSCEOLC Response to Questions on Notice, undated, at 4.

200 Royal Australian and New Zealand College of Psychiatrists (WA), JSCEOLC Submission 391 at 4-5.

201 Monforte Royo et al (2012) 'What Lies Behind the Wish to Hasten Death? A Systematic Review and Meta-Ethnography from the Perspective of Patients,' *PLoS ONE* 7(5), e37117 doi:10.1371/journal.pone.0037117 at 14-15.

**Finding 19**

It is inherently complex to determine the influences on drivers to seek end of life in an individual with mental illness.

**Finding 20**

A single psychiatric visit to assess capacity is inadequate to determine whether a psychiatric disorder is impairing the judgment of a patient seeking assisted suicide.

**Finding 21**

Diagnosing demoralisation is as important as diagnosing depression and other conditions when seeking to alleviate and manage psychological suffering.

**Finding 22**

Access to consultation-liaison psychiatry in Western Australia is poor.

**Recommendation 7**

The Minister for Health should develop a plan to increase the number of consultation-liaison psychiatrists in Western Australia.

**Finding 23**

The introduction of a legalised assisted suicide regime in Western Australia would present a grave risk to patients, especially those in an advanced stage of their illness whose wish for hastened death has not been assessed and addressed by a specialised consultation-liaison psychiatrist.

**Mandatory psychiatric assessment cannot eliminate error in capacity assessment**

- 2.46. Mandatory psychiatric assessment of patients does not, however, eliminate error in capacity assessment since the assessment criteria for mental illness will have subjective weighting and analysis based on the skill and experience level of the individual clinician. Furthermore, it is not uncommon for clinicians to disagree on the nature of an individual's mental illness.<sup>202</sup> Parker notes, in a study of 94 capacity decisions by the Queensland Guardianship and Administrative Tribunal involving evidence from more than one health professional expert, 27 (28.7 per cent) demonstrated disagreement between the experts concerning capacity. This was not a disagreement over the level of capacity, but a disagreement about the possession of capacity.<sup>203</sup>
- 2.47. Dr Gibson also gave evidence to the Committee that two specialist practitioners, such as psychiatrists and geriatricians, could disagree on an assessment of capacity, and this

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202 Dr Gibson, Chief Psychiatrist of Western Australia, JSCEOLC Submission 655 at 3.

203 Parker M (2008) 'Patient competence and professional incompetence: Disagreements in capacity assessments in one Australian jurisdiction, and their educational implications' 16 *JLM* 25.

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disagreement was more likely to occur in the 'borderline cases.'<sup>204</sup> He suggests that 'It is not necessarily about erring; it is about complexity of that grey zone.'<sup>205</sup> He goes on to note that:

*That is where it is, again, a stakes issue, because some depression can be difficult to diagnose in certain cohorts, especially in someone who is on lots of medications, in someone who is perhaps in pain; it can be tricky to diagnose depression. You might have two psychiatrists who have different opinions on that as well. It is not an easy, lay-down misère diagnosis.<sup>206</sup>*

- 2.48. Professor PE Mullen also refers to her own failure, as a leading forensic psychiatrist, to identify depression in her patients:

*I have, on more occasions than I care to recall, failed professionally to recognise depression because I have been caught up in, and dazzled by, the tragedy of my patient's life. I have accepted their wish for death as a rational and proper desire only to have seen their desires melt away with their depression when... less involved colleagues treated the process in which the patients were trapped.<sup>207</sup>*

- 2.49. Dr Miller gave evidence to the Committee that psychiatric assessment of capacity for the purposes of assisted suicide would be problematic:

*Certainly, with the nature of assessment of decision-making in my business, particularly because I look after people with primary brain tumours, it is important to understand that decision-making exists on a continuum, but people move backwards and forwards along that continuum depending on the nature perhaps of their tumour, the side effects of treatments that they might be experiencing, the progression of the underlying disease process, and the response to treatments. The notion that it is a black and white sort of idea does not map to the reality of what I see. But I can see that it would also be very difficult, if I were in a position to be someone who is undertaking assessments, the due diligence that would be required for such an assessment in terms of getting a sense of all the issues that might be impacting on that person's level of their expressed wish, and then trying to determine what needs have been met and what needs are not met, and at what point does my*

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204 Dr Gibson, Chief Psychiatrist of Western Australia, JSCEOLC Transcript, 28 February 2018, Session 3 at 2-3.

205 Ibid.

206 Ibid at 6.

207 Zalberg JR and Buchanan JD (1997) 'Clinical issues in euthanasia' *MJA* 166 at 151, quoting PE Mullen (1995) 'Euthanasia: an impoverished construction of life and death' *J Law Med* 3, 121-128.

*assessment become one of a therapeutic intervention. What happens if that person says, "Can I come back and see you to discuss this later?" In terms of resource implications, I think we probably need to be aware of those as broader issues, and certainly access to specialist liaison psychiatry and, indeed, to specialist palliative medicine does vary around the state.<sup>208</sup>*

- 2.50. This reflects the concerns of Kissane, who writes that:

*This assessment role [psychiatric assessment in assisted suicide applications] may be perceived as adversarial and not conducive to the development of a therapeutic alliance, upon which successful counselling must depend. Duty of care requires an appropriate trial of proper treatment, with thorough attention to diagnosis, choice and dose of medication, length and variation of therapy, and second opinion if the clinician is unfamiliar with the clinical circumstances present.<sup>209</sup>*

- 2.51. Concern was also expressed by RANZCP(WA) about the resource implications and their fear that mandatory psychiatric assessment of capacity in assisted suicide applications would take psychiatrists away from already needed basic palliative care.<sup>210</sup> In their submission to the Committee, RANZCP(WA) note that

*Additionally, due to resourcing and access issues, consultation-liaison psychiatry services are currently not able to see many patients with a therapeutic need for psychiatric assessment at the end of life (to enable detection and treatment of mental health comorbidities which may impact on their burden of suffering and thus on their desire to pursue PAS). It would be very concerning to see a situation by which current critically stretched services are expected to absorb the significant burden of complex medico-legal assessments, when earlier access to therapeutic intervention may have removed the need for this.*

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*The WA Branch is very concerned that the introduction of PAS legislation may mean that the scarce existing resources in consultation-liaison and palliative care are diverted from providing timely service to people with treatable illness into providing the medico-legal assessments. The*

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208 Dr Miller, Clinician, Consultant Liaison Psychiatrist in Cancer and Palliative Care, JSCEOLC Transcript, 13 December 2017, Session 4 at 3-4 (emphasis added).

209 Kissane DW (2000) 'The Challenge of Informed Consent,' *Journal of Pain and Symptom Management* 19(6) at 473.

210 Dr Moore, Branch Chair, Royal Australian and New Zealand College of Psychiatrists (WA), JSCEOLC Transcript, 28 February 2018, Session 5 at 5.

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*impact of the administrative burden that was imposed by the implementation of the Mental Health Act 2014 has been felt across mental health services and the WA Branch would recommend that this situation be avoided.*<sup>211</sup>

- 2.52. The experience in the Northern Territory under the operation of the *Rights of the Terminally Ill Act 1995* (NT) (ROTI Act) also reveals that mandatory psychiatric assessment does not safeguard vulnerable patients. The mandatory system in the Northern Territory signally failed to adequately identify depression, demoralisation or other psychiatric issues which may have been treatable in all four cases of persons euthanised under that regime. The Northern Territory experience evidences that 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 is affected by depression or other psychiatric factors is clearly an inadequate safeguard and will not make assisted suicide 'safe.'<sup>212</sup> Using psychologists or psychiatrists as gatekeepers only to establish a patient's capacity to make a decision for assisted suicide contributes to pro forma, meaningless consultations.<sup>213</sup>
- 2.53. It is clear that no assisted suicide legislation, even with mandatory psychiatric assessment requirements, can safeguard against the assisted suicide of a person suffering from a treatable mental illness and, if for no other reason, assisted suicide should not be legalised in Western Australia.

### **Finding 24**

Mandatory psychiatric assessment cannot eliminate error in capacity assessments.

### **Finding 25**

No assisted suicide regime, even with mandatory psychiatric assessment, can safeguard against the assisted suicide of a person suffering from a treatable mental illness.

## **Voluntary and Informed Consent**

- 2.54. There are three elements for a valid consent to or refusal of medical treatment, being (a) the capacity of the person, (b) the knowledge of what is about to take place with the treatment, and, also very importantly, (c) the voluntariness of that decision.<sup>214</sup>

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211 Royal Australian and New Zealand College of Psychiatrists (WA), JSCEOLC Submission 391 at 7 and 9 (emphasis added).

212 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 13.

213 Golden and Zoanni (2010) 'Killing Us Softly: The Dangers of Legalizing Assisted Suicide,' *Disability and Health Journal* 3(1), 16-30 at 24, quoting Hendin and Foley (2008) 'Physician assisted suicide: a medical perspective,' *Michigan Law Review* 106, 1613-1640.

214 Assoc Prof Blake, UWA, JSCEOLC Transcript, 26 February 2018, Session 3 at 12.



### Informed consent

- 2.55. The importance of informed consent in medical decision making was highlighted by Associate Professor Meredith Blake, Legal Researcher at the University of Western Australia, in evidence given to the Committee. Associate Professor Blake suggested that an assisted suicide model in Western Australia might require the delivery and communication and taking in of certain amounts of information that would not be required in relation to a minor or standard medical procedure.<sup>215</sup> This suggestion is understandable given the stakes are self-evidently so much higher for the patient.
- 2.56. Peled et al note that patient autonomy is violated if options that potentially lead to a different choice are not provided.<sup>216</sup> They suggest that autonomy concerns in relation to assisted suicide are not merely theoretical and that site studies have shown that less than one half of clinic outpatients surveyed in Oregon knew that life support could be withdrawn or that pain can be aggressively managed by increasing medication doses. Also in Oregon, physicians surveyed from 1997 to 1999 reported that 30 per cent of patients who initially sought physician-assisted dying (PAD) received interventions that later altered their desire for PAD. Patients who received substantive interventions (control of pain or other symptoms; antidepressant trial; or referral to palliative care, hospice, mental health, social work, or chaplaincy) were three times more likely to change their minds about PAD than those who did not.<sup>217</sup>
- 2.57. Dr Koh, Chair of the RACGP, gave evidence to the Committee that when asked by patients for euthanasia to be given to them, a broader discussion around the end of life could then be had and that many patients, while of sound mind, do not understand the journey of palliative care and of end of life.<sup>218</sup> The autonomy of patients requesting assisted suicide in Western Australia will be violated if assisted suicide is sought in the absence of knowledge of other quality end of life care options available to them. Evidence was given to the Committee that not only is the general community not aware of the breadth of available palliative care options, many health professionals are also hold that same lack of awareness.<sup>219</sup> If the patient is not aware of their full palliative care options, and

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215 Ibid.

216 Peled et al (2017) 'Enhancing Informed Consent for Physician Aid in Dying: Potential Role of Handout on Possible Benefits of Palliative Care' *American Society of Clinical Oncology* <<https://doi.org/10.1200/JOP.2017.021105>> at 2.

217 Ibid at 3, citing Ganzini et al (2000) 'Physicians' experiences with the Oregon Death with Dignity Act,' *N Engl J Med* 342, 557-563.

218 Dr Koh, Chair, Royal Australian College of General Practitioners (WA), JSCEOLC Transcript, 14 December 2018, Session 1 at 15.

219 Palliative Care WA, JSCEOLC Responses to Questions on Notice, at 3; Silver Chain, JSCEOLC Response to Questions on Notice, at 2; Dr Bradley, Palliative Care Clinical Lead, WA Cancer and Palliative Care Network, Department of Health, JSCEOLC Transcript, 13 December 2017, Session 1 at 21; Ms Calcutt, Project Officer, Palliative Care WA, JSCEOLC Transcript, 9 April 2018, Session 3 at 8; Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 18 May 2018, Session 1 at 3; Mrs Buchanan, Committee Member, Palliative Care Nurses Australia, JSCEOLC Transcript, 14 December 2017, Session 2 at 5; Dr Campbell, President, Palliative Care WA, JSCEOLC Transcript,

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the consulting doctor is not aware of these options either, it cannot be said that the patient's request for assisted suicide is informed.

- 2.58. Whilst knowledge is a core component of informed consent, access to the known options is just as important to ensure the knowledge is more than merely theoretical. Informed consent to assisted suicide cannot be obtained unless good palliative care is actually available to the patient. A failure to appropriately control a patient's pain or to provide access to palliative care can result in requests for euthanasia which cannot properly be termed voluntary.<sup>220</sup> It is arguable that the euthanasia of at least one of the patients under the Northern Territory's ROTI Act could not be termed voluntary. With reference to the patient suffering from mycosis fungoides, Kissane notes that the voluntariness of her choice for euthanasia was influenced by her not being informed of the availability of effective treatment for depression nor being given the opportunity to have her suffering alleviated.<sup>221</sup> Arguably the lack of specialist palliative care in the Northern Territory at the time of the operation of the ROTI Act could also be said to influence the voluntariness of all of the requests for euthanasia made during that period. Indeed the same issues arise here in Western Australia, where the Committee has heard evidence that up to 60 per cent of Western Australians do not have access to the palliative care that they require.<sup>222</sup>
- 2.59. Whether informed consent is given by a patient is also dependent on a patient's mental condition. It is suggested that demoralised patients may also not be capable of making a truly informed decision in giving medical consent.<sup>223</sup> Chochinov et al note that:

*Although concurrent depression does not necessarily imply that a desire for death is implicitly "irrational," the reasoning processes of depressed patients are characteristically biased by negative mental sets that may affect their capacity to make well-considered life-and-death decisions. Furthermore, demoralisation and a lack of assertiveness may render the*

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14 December 2017, Session 4 at 8 and 13-14; Mrs Matthews, Individual Submitter, JSCEOLC Transcript, 27 February 2018, Session 3 at 9; Prof Doug Bridge, Senior Palliative Care Specialist, UWA Faculty of Medicine and Health Sciences and WA Country Health Service, Royal Perth Hospital, JSCEOLC Transcript, 9 March 2018, Session 5 at 1.

220 Strinic V (2015) 'Arguments in Support and Against Euthanasia,' *British Journal of Medicine and Medical Research* 9 at 4 – cited in Quinlan M (2016) "'Such is Life': Euthanasia and capital punishment in Australia: consistency or contradiction?' *Solidarity: The Journal of Catholic Social Thought and Secular Ethics* 6(1) at 12.

221 Kissane DW (2000) 'The Challenge of Informed Consent,' *Journal of Pain and Symptom Management* 19(6) 473-4 at 473.

222 Palliative Care WA, JSCEOLC Response to Questions on Notice, 19 December 2017 at 3, citing Palliative Care Outcomes Collaboration (PCOC) data (2017) Australian Health Services Research Institute, University of Wollongong.

223 Kissane DW (2002) 'Deadly days in Darwin,' in *The Case Against Assisted Suicide*, Foley & Hendin (eds), Johns Hopkins University Press, at 192-209, quoted by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 12.

*depressed terminally ill patient more vulnerable to the suggestions of others, thereby increasing the potential for abuse.*<sup>224</sup>

- 2.60. Undue influence and the abuse of vulnerable patients is further considered below.

### **Finding 26**

A valid consent to medical treatment is dependent on the:

- a) capacity of the patient;
- b) patient's knowledge of the treatment options; and
- c) the voluntariness of the decision.

### **Undue influence**

- 2.61. Although someone may have capacity, they may still be unduly influenced so as to make a decision which is not made voluntarily or of their own free will. Mr Cameron Eastwood, a Western Australian legal practitioner, explained in his evidence to the Committee that undue influence is a legal construct that can be defined as the improper use by someone of an ascendancy over another person, to derive benefit for themselves or a third party by coercing actions from overborne person that are not free, voluntary acts. The nature of the relationship between the parties (one of ascendancy by one person over the other) is the foundation of the influence. Risk factors of undue influence include older age, family conflict, isolation, physical disability, mental disorder, recent bereavement and language difficulties.<sup>225</sup>
- 2.62. In relation to undue influence in medical decision making, Lord Donaldson MR of the English Court of Appeal, Civil Division, stated the matter to be considered as follows:

*A special problem may arise if at the time the decision is made the patient has been subjected to the influence of some third party. This is by no means to say that the patient is not entitled to receive and indeed invite advice and assistance from others in reaching a decision, particularly from members of the family. But the doctors have to consider whether the decision is really that of the patient. It is wholly acceptable that the patient should have been persuaded by others of the merits of such a decision and have decided accordingly. It matters not how strong the persuasion was, so long as it did not overbear the independence of the patient's decision. The real question in each such case is "Does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer*

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224 Chochinov et al (1995) 'Desire for death in the terminally ill' *The American Journal of Psychiatry* 152(8) 1185-91.

225 Mr Eastwood, Legal Practitioner, JSCEOLC Response to Questions on Notice, 20 April 2018 at 3.

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think and decide for himself?" In other words "Is it a decision expressed in form only, not in reality?"

*When considering the effect of outside influences, two aspects can be of crucial importance. First, the strength of the will of the patient. One who is very tired, in pain or depressed will be much less able to resist having his will overborne than one who is rested, free from pain and cheerful. Second, the relationship of the "persuader" to the patient may be of crucial importance. The influence of parents on their children or of one spouse on the other can be, but is by no means necessarily, much stronger than would be the case in other relationships. Persuasion based upon religious belief can also be much more compelling and the fact that arguments based upon religious beliefs are being deployed by someone in a very close relationship with the patient will give them added force and should alert the doctors to the possibility - no more - that the patient's capacity or will to decide has been overborne. In other words the patient may not mean what he says.<sup>226</sup>*

- 2.63. The possibility that a patient may be influenced by their family to seek assisted suicide is not far-fetched. 'Cries for help' also come from families, who often suffer deeply when a relative has a life-threatening illness, and the incidence of depression in families correlates with its incidence in patients. 'Can't it all end? Isn't there an easier way?' are commonly heard pleas from family members of patients.<sup>227</sup> In a study of relatives and acquaintances of more than 3000 patients who had died, about a quarter of respondents had wished for the patient's earlier death, but only 3.6 per cent of the patients had specifically discussed the issue of euthanasia.<sup>228</sup>
- 2.64. It is also possible that a medical adviser may exert undue influence on a patient. Stewart and Lynch also discuss the application of undue influence to cases involving a medical adviser influencing a patient to consent to or withhold consent from a medical procedure. They consider the case of *Centre for Reproductive Medicine v Mrs U*,<sup>229</sup> which involved a claim by a widow that her late husband's withdrawal of consent for the posthumous use of his sperm for IVF had been unduly influenced by a nurse at the clinic and conclude that, notwithstanding the decision in that case, undue influence by a medical adviser may emerge as a factor in the validity of consents to medical treatment.

*Why Mrs U is both different and important is that it concerns the influence emanating not from a third party but from the health*

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226 Lord Donaldson MR in *Re T* [1992] EWCA Civ 18 (30 July 1992) at 31-32 (emphasis added).

227 Zalberg JR and Buchanan JD (1997) 'Clinical issues in euthanasia,' *MJA* 166 150 at 150.

228 Seale C and Addington-Hall J (1994) 'Euthanasia: why people want to die earlier,' *Soc Sci Med* 39, 647-654.

229 Unreported, High Court of Justice, Family Division, The President, 25 January 2002.

*professional directly. The Court of Appeal's reluctance to extend the equitable rules traditionally governing property transactions is understandable. But in acknowledging that they 'may have a part to play', the Court presents the possibility that patients may subsequently claim that their consent to or refusal of treatment was unduly influenced by a doctor. Although Mrs U maintains the strict test as to what that influence must amount to, it is not difficult to imagine that in many medical cases a weakened patient simply trusts the doctor's opinion and accedes to what is recommended.*

*Although the findings in Mrs U seem to foreclose the possibility that undue influence will acquire any immediate significance in the law of consent and the liability of doctors for treatment, they do not entirely dismiss the extension of the concept into that domain.<sup>230</sup>*

- 2.65. Some proponents of assisted suicide do not see the undue influence of a medical practitioner as an issue. In evidence to the Committee, in relation to the prohibition in the Victorian legislation against doctors raising the issue of 'voluntary assisted dying' with their patients, Dr Brian Hennessy stated 'My opinion is that doctors should be able to raise it with the patient, but the Victorian legislation was never going to get through two houses of Parliament without that phrase, so I think that was political pragmatism.'<sup>231</sup>

- 2.66. Dr Richard Lugg, Doctors for Assisted Dying Choice also wanted:

*to place on the record our view our view that this is an important reason why a ban on doctors raising the option of VAD is not actually in the best interests of patients with unbearable suffering at the end of life. In any event, as doctors, I think we would consider it an unconscionable interference in the doctor–patient relationship. All treatment options should be on the table when doctors and patients are talking, and we think there should be no such ban.<sup>232</sup>*

- 2.67. However, in a Committee hearing Mr John McGrath, Committee member said:

*That is a good point that you make. A lot of people have made that point to us—that physicians or GPs should not be encouraging people in any way at all; it should be the person's decision if they really come to that point in their life or they are close to passing. I do not think society would*

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230 Cameron Stewart and Andrew Lynch (2003) 'Undue influence, consent and medical treatment,' *Journal of the Royal Society of Medicine* 96, 598-601.

231 Dr Hennessy, Head of Anaesthesia Department, Sir Charles Gairdner Hospital, JSCEOLC Transcript, 30 April 2018, Session 1 at 14.

232 Dr Lugg, Doctors for Assisted Dying Choice, JSCEOLC Transcript, 26 February 2018, Session 4 at 5.

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*want GPs out there advertising that you can do this or telling their patients that this is an option for them.*<sup>233</sup>

- 2.68. The issue of medical practitioner influence was also identified by the Professionalism and Human Rights Committee of the American College of Physicians, in their statement that:

*Physicians can influence patients, even in ways physicians may not appreciate. Patients seeking physician assisted suicide may seek validation to end their lives. Indeed, studies have shown that socially isolated, vulnerable persons seek social support and contact through visits with their physicians. Physicians may influence patients based on their own fears of death and disability.*<sup>234</sup>

- 2.69. Countertransference was explained to the Committee by Dr Miller, where she states:

*Countertransference came originally from the psychoanalytic literature and relates to the feelings that an individual generates. The context was as a therapist towards the person, in essence. There is a transference from the person to the therapist, and a countertransference back in the other direction... Sometimes, people with challenging needs might generate a strong response either at an emotional level or even expressed at a behavioural level in people around them, where it generates a strong response. Sometimes, although it is not the classical meaning of the word, we sometimes talk about countertransference of health professionals towards challenging patients.*<sup>235</sup>

- 2.70. The danger of this countertransference, or this projection of health care worker emotions and meanings on to the patient's experience was also identified by Magnusson in *Angels of Death: Exploring the Euthanasia Underground*:

*Kerry points out that the danger for nurses who have worked extensively in HIV and have witnessed terrible deaths is to project their own emotions and meanings on to the patient's experience, to agree with the patient's sense of suffering and futility in a way that legitimates and encourages suicidal ideation. 'I often hear nurses saying things like: 'I*

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233 Mr John McGrath, Committee Member, to Mr Byl, Private Citizen, JSCEOLC Transcript, 1 May 2018, Session 6 at 4.

234 Snyder, Sulmasy and Mueller (2017) 'Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper,' Professionalism and Human Rights Committee of the American College of Physicians, *Annals of Int Med* 167(8) 576, citing Gerst-Emerson and Jayawardhana (2015) 'Loneliness as a public health issue: the impact of loneliness on health care utilisation among older adults,' *Am J Public Health* 105, 1013-9 and Miles SH (1994) 'Physicians and their patients' suicides,' *JAMA* 271, 1786-8.

235 Dr Miller, Clinician, Consultant Liaison Psychiatrist in Cancer and Palliative Care, JSCEOLC Transcript, 13 December 2017, Session 4 at 6.

*don't know why they're hanging around, I don't know why they don't just give up." The danger is in the thinking: "Yes it is terrible, I've seen a hundred people die that way; yes—die!", instead of listening to what the person is saying which may be about "I'm frightened of something, I'm scared of suffering."<sup>236</sup>*

2.71. And further:

*Healthcare workers may project their own sense of horror and repulsion, in subtle ways, on to the patient, thereby reinforcing patients' sense of futility. This raises difficult issues. Being a sounding board, and providing 'emotional accompaniment' are a part of caregiving, and these benefits could hardly come from an emotionally remote carer. But risks may arise when care workers are themselves burned out, or fail to recognise the fragility of their patients and the extent of their influence over them.<sup>237</sup>*

#### **Finding 27**

Countertransference and/or undue influence from a medical practitioner would be two dangerous risks in any assisted suicide regime.

#### **Undue influence and elder abuse**

2.72. As already noted, the risk factors for undue influence include older age, family conflict, isolation, physical disability, mental disorder, recent bereavement and language difficulties.<sup>238</sup> In light of these risk factors, and the epidemic of elder abuse that is only now coming to light in Western Australia, it would be unconscionable for the Western Australian Parliament to legalise assisted suicide.

2.73. The Legislative Council of Western Australian established a Select Committee on Elder Abuse on 13 September 2017. Its terms of reference are:

- a) *determine an appropriate definition of elder abuse;*
- b) *identify its prevalence;*
- c) *identify the forms of elder abuse, including but not limited to neglect;*
- d) *identify the risk factors;*
- e) *assess and review the legislative and policy frameworks;*

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236 Magnusson RS (2002) *Angels of death: exploring the euthanasia underground* at 92-93.

237 Ibid at 251-2.

238 Mr Eastwood, Legal Practitioner, JSCEOLC Response to Questions on Notice, 20 April 2018 at 3.

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- f) *assess and review service delivery and agency responses;*
- g) *the capacity of the Western Australia Police to identify and respond to allegations of elder abuse;*
- h) *identify initiatives to empower older persons to better protect themselves from risks of elder abuse as they age;*
- i) *consider new proposals or initiatives which may enhance existing strategies for safeguarding older persons who may be vulnerable to abuse; and*
- j) *consider any other relevant matter.*

- 2.74. The Select Committee on Elder Abuse recently made public the paper *Elder Abuse Protocol: Guidelines for Action* (2017), published by the Western Australian Alliance for the Prevention of Elder Abuse (APEA). The World Health Organisation (WHO) definition of 'elder abuse' is adopted in the Guidelines, which is defined as 'a single act, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.'<sup>239</sup>
- 2.75. The Guidelines note that the WHO estimates that 15.7 per cent of people 60 years and older in the community may have experienced abuse. This means that potentially over 75,000 older Western Australians are affected. The Guidelines note that this number may be a lot higher for people in 'at-risk' categories, including older people with physical or mental incapacity and people living in institutional settings. Figures of reported elder abuse are likely to underestimate prevalence due to the fact that only a small fraction of cases are reported.<sup>240</sup>
- 2.76. Evidence was heard by the Select Committee on Elder Abuse in a public hearing with Dr Helen McGowan, of the Older Adult Mental Health Sub-Network, that it is much more difficult to quantify psychological and mental abuse, than the financial abuse of older adults. Dr McGowan also noted that an older age Western Australian is much more likely to experience elder abuse if that person is chronically ill. Of particular note was her evidence that the capacity of general practitioners to identify elder abuse in their patients is 'incredibly variable.'<sup>241</sup>

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239 World Health Organization (2002) 'The Toronto Declaration of the Global Prevention of Elder Abuse,' at 3, cited in WA Alliance for the Prevention of Elder Abuse (APEA) (2017) *Elder Abuse Protocol: Guidelines for Action* at 4.

240 WA Alliance for the Prevention of Elder Abuse (APEA) (2017) *Elder Abuse Protocol: Guidelines for Action* at 5.

241 Dr Helen McGowan, Psychiatrist of Old Age and Clinical Co-Lead, WA Mental Health Network, Older Adult Mental Health Sub-Network, Select Committee on Elder Abuse Transcript, 21 May 2018, Session 1 at 10.



- 2.77. Evidence was also heard from Mr Michael Bowyer, Principal Legal Officer of the Public Trustee, that the prosecution of elder abuse cases is a real issue in that 'it is very difficult when your best witness cannot give evidence.'<sup>242</sup>
- 2.78. Case study evidence was given to the Select Committee on Elder Abuse by Advocare, a community based advocacy organisation for older adults and people with disabilities. One such case study involved an elderly man diagnosed with terminal cancer and dementia who, with the support of his family (other than his son), had declined futile treatment and had accepted palliative care support in the home. Services were set up for the man but his son, who had a history of issues associated with mental ill-health and drug and alcohol abuse, prevented these palliative care services from access to the home.<sup>243</sup>
- 2.79. A Senior Rights Victoria summary of case law and best practice on undue influence in the financial abuse of elders reveals that undue influence can be easily missed and may be difficult to identify.<sup>244</sup> A recent parliamentary report on elder abuse in New South Wales also referenced the failure of professionals to identify undue influence and so unwittingly facilitate elder abuse.<sup>245</sup> The NSW report 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.<sup>246</sup>
- 2.80. It is also worth noting here that in cases of undue influence in matters of financial elder abuse, courts can apply the remedy of rescission. However, what remedy will there be for older Western Australians for whom undue influence has affected their decision to undergo assisted suicide?
- 2.81. Mr Eastwood suggests that an increase in these types of abusive behaviour will occur, with regard to the published research into the increasing prevalence of elder abuse, the

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242 Mr Michael Bowyer, Principal Legal Officer, Office of the Public Trustee, Select Committee on Elder Abuse Transcript, 26 March 2018, Session 2 at 15.

243 Advocare Inc (2018) 'Advocare Elder Abuse recent case studies demonstrating the complex nature of Elder Abuse,' Select Committee on Elder Abuse, Western Australia, Advocare tabled paper (2), 12 March 2018.

244 Senior Rights Victoria, <<https://assetsforcare.seniorsrights.org.au/relationship-breaks-down/equity/undue-influence-unconscionable-dealing/>> referred to by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 23.

245 NSW Legislative Council, General Purpose Standing Committee No. 2, Elder Abuse in New South Wales, June 2016, cited in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 23.

246 NSW Legislative Council, General Purpose Standing Committee No. 2, Elder Abuse in New South Wales, June 2016, at 80, cited in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 23-24.

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proportional ageing of the population and an increased incidence of dementia in our elderly population.<sup>247</sup>

- 2.82. Professors White and Willmott identify the elderly as a vulnerable group, but claim that there is no evidence that such persons have been at increased risk in countries with assisted suicide.<sup>248</sup> In response to this assertion, Ms Marina Re, Chief Executive Officer of IdentityWA, writes

*Clearly there is no such evidence of those at risk of family coercion or those with disability where no such data has been gathered against these measures. In examining Oregon Health Authority's (OHA) most recent report for 2017, the following observations are offered: For those at risk of family coercion, Oregon [Dying With Dignity Act] requires that the patient needs to be known by doctor. This could be a means to detect possible coercion through witnessing family dynamics. However, the OHA 2017 report shows that the median length of the patient-doctor relationship is just 10 weeks, and in some cases only one week. It is noted that the doctors complete the documentation: a standardised box-ticking exercise for demographic information that reduces responses to generic categories which cannot penetrate the depth patients' subjective experiences and motivations. One possible measure for family coercion would be the sense of "being a burden," which the OHA 2017 report shows to be 55%. It is noted that this ranks above "concern about pain" (21%) as the reason for accessing the DWDA. [Professors White and Willmott] identify the elderly as a vulnerable group. Their claim that there is no evidence to support an increased risk to them is refuted in the OHA 2017 report which shows that the median age is 72 years. Elder abuse is a real and burgeoning problem in Australia. We submit that euthanasia or assisted suicide will not improve this problem.<sup>249</sup>*

- 2.83. The vulnerability of a frail, elderly or ill person to subtle coercion and undue influence was recognised by Sir James Hannen in the 1885 case of *Wingrove v Wingrove*:

*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*

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247 Mr Eastwood, Legal Practitioner, JSCEOLC Transcript, 8 March 2018, Session 1 at 2.

248 Willmott and White (2017) 'Assisted Dying in Australia: A Values-based Model for Reform,' in *Tensions and Traumas in Health Law* at 496-7, submitted in Professors Willmott and White, Directors, Australian Centre for Health Law and Research and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, JSCEOLC Submission 560A.

249 Ms Marina Re, Chief Executive Officer, IdentityWA, JSCEOLC Response to Questions on Notice, 10 April 2018 at 2-3.

*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 quiteness' sake, to do anything. This would equally be coercion, though not actual violence.*<sup>250</sup>

- 2.84. Mr Richard Egan, Defend Human Life!, argues that in light of this statement by Justice Hannen, simply requiring a physician to tick a box stating that the person requesting assisted suicide is doing so voluntarily is no guarantee that the physician has the competence or has undertaken the extensive and careful inquiries necessary to establish that the person is not subject to undue influence or subtle pressure (albeit unwittingly) from family, friends or society to request assisted suicide so as not to burden others. He argues that no jurisdiction that has legalised assisted suicide has even made any serious effort to establish a genuinely safe framework in this regard.<sup>251</sup>
- 2.85. Associate Professor Blake gave evidence to the Committee that 'safeguards' could be included in assisted suicide legislation to ensure voluntary and informed consent, but the weakness of such procedural 'tick a box' safeguards is evident in the following comment by Associate Professor Blake in a Committee hearing:

*We can have safeguards. We can have ways of best practice and ways of demonstrating that, with this evidence, we can feel comfortable that this person has the capacity to make this decision, has received all the appropriate information and understood it, and has made this decision free of undue influence. That is all we can do, really, because we cannot climb into somebody else's head.*<sup>252</sup>

- 2.86. That the safeguards against coercion or undue influence are the doctors themselves, rather than prescriptive 'safeguards' or 'best practice' models is clear in an exchange between Mr Marshall Perron, assisted suicide advocate, and Hon Nick Goiran MLC in a Committee hearing:

*Mr PERRON: I believe that the duress question, which is in virtually all legislation, including the Northern Territory legislation, is one of the criteria that is assessed by two doctors in almost all cases of safeguards, and I believe that considering these are not short meetings between doctor and patient, I think that the demeanour of the patient could be*

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250 Sir James Hannen in *Wingrove v Wingrove* [1885] 11 PD 81, quoted by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 24.

251 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 24.

252 Assoc Prof Blake, UWA, JSCEOLC Transcript, 26 February 2018, Session 3 at 13.

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*assessed by doctors reasonably, particularly two of them, including the question of whether they are acting under coercion.*

*Hon NICK GOIRAN: So the safeguards are the doctors?*

*Mr PERRON: In this case, yes.*

*Hon NICK GOIRAN: Should those doctors have had some rapport with the patient?*

*Mr PERRON: Not necessarily.<sup>253</sup>*

- 2.87. And yet, Dr Khorshid of the AMA(WA) also notes that medical practitioners:

*are not skilled in legal decisions, we are not skilled in knowing what underlying motivations there might be behind a decision to proceed with euthanasia, we are not skilled at knowing whether coercion is occurring, we are not skilled at knowing the impact of a will on a family when we are talking about these complex decisions at end of life... this is such a high stakes decision, it would be unconscionable to get it wrong or to put in a structure that was ripe for abuse or that just did not achieve the outcomes that they were all hoping for.<sup>254</sup>*

- 2.88. Elder law expert Ms Margaret Dore goes one step further than Mr Egan, to suggest that a legislative assisted suicide scheme officially sanctions the abuse of vulnerable adults. Data from Oregon shows that in 2016 nearly one out every two (48.7 per cent) patients who died after taking prescribed lethal medication cited concerns about being a ‘burden on family/caregivers’ as a reason for the request.<sup>255</sup> Ms Dore states:

*In both Washington and Oregon, the official reporting forms include a check-the-box question with seven possible “concerns” that contributed to the lethal dose request. These concerns include the patient's feeling that he was a “burden.” The prescribing doctor is instructed: “Please check ‘yes,’ ‘no,’ or ‘don’t know’ depending on whether or not you believe that a concern contributed to the request.”*

*In other states, a person being described as a “burden” is a warning sign of abuse. For example, Sarah Scott of Idaho Adult Protection Services describes the following “warning sign:” “Suspect behavior by the*

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253 Mr Marshall Perron, Private Citizen, JSCEOLC Transcript, 13 April 2018, Session 2 at 7.

254 Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 18 May 2018, Session 1 at 6.

255 Oregon Public Health Division (2017) ‘Oregon Death With Dignity Act: Data Summary 2016, Table 1. Characteristics and end-of-life care of 1,127 DWDA patients who have died from ingesting a lethal dose of medication as of January 23, 2016 [sic = 2017], by year,’ Oregon, 1998-2016 at 10, cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 22.

*caregiver... [d]escribes the vulnerable adult as a burden or nuisance.” The recommendation is that when such “warning signs” exist, a report should be made to law enforcement and/or to the local adult protective services provider.*

*Washington and Oregon, by contrast, instruct its doctors to check a “burden” box. Washington and Oregon promote the idea that its citizens are burdens, which justifies the prescription of lethal drugs to kill them. Washington’s and Oregon’s Acts do not promote patient “control,” but officially sanctioned abuse of vulnerable adults.<sup>256</sup>*

- 2.89. Concerns about pressure on the elderly to seek assisted suicide have been widely expressed in the assisted suicide debate in Australia. Former Labor Prime Minister Kevin Rudd expressed his concern in this way:

*What I am deeply worried about is one simple practical question, which is: at the point at which an older person concludes that they are sick, they are very sick, and that they have become a burden on their families or their community, the pressure now transfers to them in terms of making a decision about their life’s future. And I cannot have any confidence that, and I do not believe, we should place that burden on people in their later years.<sup>257</sup>*

- 2.90. Similar concerns were also expressed by another former Labor Prime Minister Paul Keating:

*it is “commonplace” for patients to tell doctors in front of their loved ones that they have no wish to be a burden on their families. Once this bill is passed the expectations of patients and families will change. The culture of dying, despite certain and intense resistance, will gradually permeate into our medical, health, social and institutional arrangements. It stands for everything a truly civil society should stand against. A change of this kind will affect our entire community not just a small number of dying patients. It is fatuous to assert that patients will not feel under pressure once this bill becomes law to nominate themselves for termination.<sup>258</sup>*

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256 Dore MK (2010) “Death With Dignity”: A Recipe for Elder Abuse and Homicide (Albeit Not by Name)’ *Marquette Elder’s Advisor* 11(2) quoted by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 21-22.

257 Kevin Rudd quoted in John Ferguson and Troy Bramston, ‘Victoria’s euthanasia bill confronts new hurdle,’ *The Australian*, 24 October 2017.

258 Paul Keating, ‘Voluntary euthanasia is a threshold moment for Australia, and one we should not cross,’ *Sydney Morning Herald*, 19 October 2017.

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- 2.91. Hon Paul Keating also quotes Dr Michael Gannon, the then President of the Australian Medical Association, who said:

*Once you legislate this you cross the Rubicon. The cause for euthanasia has been made in a very emotional way and this is the latest expression of individual autonomy as an underlying principle. But the sick, the elderly, the disabled, the chronically ill and the dying must never be made to feel they are a burden.*<sup>259</sup>

- 2.92. The legalisation of assisted suicide itself implies pressure, since society thereby proclaims that suicide is a recommended measure in certain situations.<sup>260</sup>

- 2.93. And yet, ageist stereotypes and discrimination still exist, and of most concern, are found in the statements made by proponents of assisted dying. During the debate over the Northern Territory's ROTI Act, Mr Bill Hayden urged doctors to support euthanasia as a right and a duty. He made the following comment to the College of Physicians: 'There is a point when the succeeding generations deserve to be disencumbered of some unproductive burdens.' This comment that 'unproductive burdens' should do the right thing by society was supported by the then South Australian Governor, Mr Mark Oliphant.<sup>261</sup>

- 2.94. The danger of a defeatist view on elder abuse was starkly outlined to the Committee by this evidence from a proponent of assisted suicide,

*I find that an interesting thing in view of the current abuse of the elderly. My personal feeling is that the elderly, if they are being abused or coerced, would in fact be so disillusioned, particularly if this were family members, that they would actually welcome an end to their life.*<sup>262</sup>

- 2.95. It is a sad state of affairs in Western Australia that the legalisation of assisted suicide is considered a solution for those members of our community suffering from elder abuse.

- 2.96. It is this ageism, the structural devaluation of older people within a society, that heightens the risk of elder abuse.<sup>263</sup> The APEA Guidelines submitted to the Select Committee on Elder Abuse also acknowledge that ageist stereotypes and discrimination

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259 Ibid, quoting Dr Gannon, (then) AMA President.

260 Stahle F (2017) 'Moral disengagement – Mechanisms Propelling the Euthanasia/PAS Movement,' *Journal of Ethics in Mental Health* 10 at 5.

261 Quoted by Mr Randal, President, Coalition for the Defence of Human Life, Presentation to the Select Committee on End of Life Choices, included in JSCEOLC Response to Questions on Notice, 17 April 2018 at 8.

262 Mrs Trendall, Senior Citizen, JSCEOLC Transcript, 7 March 2018, Session 1 at 2.

263 Jane Mussared, Chief Executive of the Council on the Ageing SA, 'Stopping elder abuse requires community wide effort,' 15 June 2018 <<https://indaily.com.au/opinion/2018/06/15/stopping-elder-abuse-requires-community-wide-effort>>

may lead to negative attitudes and discriminatory policies and practices by individuals and institutions.<sup>264</sup> It would be unconscionable for the Western Australian Parliament to introduce an assisted suicide regime that entrenches existing discrimination against vulnerable older Western Australians. Laws should protect those who are most vulnerable in our community. Assisted suicide is a recipe for elder abuse.

**Finding 28**

Elder abuse is a real and burgeoning problem in Western Australia.

**Finding 29**

The capacity of medical practitioners to identify elder abuse in their patients is incredibly variable in Western Australia.

**Finding 30**

Redress can be difficult in some elder abuse cases when the best witness lacks capacity to give evidence.

**Finding 31**

Redress in any assisted suicide case is an impossibility.

**Finding 32**

The presence of undue influence can be difficult to identify and is easily missed.

**Finding 33**

The introduction of a legalised assisted suicide regime in Western Australia would be a recipe for elder abuse.

**Recommendation 8**

The Minister for Seniors and Ageing should develop and roll out a comprehensive plan to tackle elder abuse in Western Australia.

**Assisted Suicide and Disability Discrimination**

2.97. There is a focus by some assisted suicide proponents to ensure that people with a disability are not discriminated against in their ability to access assisted suicide regimes:

*we note that individuals without disabilities are able to end their suffering through suicide. But this option may not be open to some individuals who have a physical disability that prevents them from doing so. Prohibiting assisted dying can thus be seen as offending the value of equality through discrimination on the basis of physical*

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264 WA Alliance for the Prevention of Elder Abuse (APEA) (2017) *Elder Abuse Protocol: Guidelines for Action* at 17.

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*disability...having a disability should not of itself prevent a person from receiving assistance under assisted dying legislation. That is, if the person satisfies the eligibility requirement of 'medical condition', he or she should not be regarded as ineligible because that medical condition results from a disability.*<sup>265</sup>

- 2.98. Removal of time limits to require a particular proximity to death has been suggested to allow persons with a medical condition, such as quadriplegia who require artificial nutrition and hydration to survive.<sup>266</sup> This position is based on the view that disability may be regarded as 'abhorrent' by the individual, and equates to a loss of dignity:

*Illnesses and diseases have different medical trajectories. Some illnesses or diseases may mean that a person is deprived of independence because he or she needs assistance from others for all aspects of living. Some individuals may find it undignified to continue to live in circumstances where they must rely on others to, eg, feed them, bathe them and assist them with toileting, and may prefer to end their lives rather than continue to live in this fashion. A competent person who forms that view should have the right to end her or his life.*

...

*Relevant to this argument is that illness and disease can result in individuals having to rely on others for all aspects of their lives, and living in a way that they regard as abhorrent. The loss of dignity may be a significant factor in deciding that life has become unacceptable, and voluntary euthanasia or assisted suicide would enable such a person to bring life to an end, and should be permitted.*<sup>267</sup>

- 2.99. Such quality of life arguments are described by Fabian Stahle as

*[A] mechanism... employed that excuses the mortal deed by reducing the human dignity and integrity of the patient. The action is justified by*

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265 Willmott and White (2017) 'Assisted Dying in Australia: A Values-based Model for Reform' in *Tensions and Traumas in Health Law* at 494, submitted in Professors Willmott and White, Directors, Australian Centre for Health Law and Research and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, JSCEOLC Submission 560A.

266 Willmott and White (2017) 'Assisted Dying in Australia: A Values-based Model for Reform' in *Tensions and Traumas in Health Law* at 504, submitted in Professors Willmott and White, Directors, Australian Centre for Health Law and Research and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, JSCEOLC Submission 560A.

267 White and Willmott (2012) 'How should Australia regulate voluntary euthanasia and assisted suicide?' *Journal of Law and Medicine* 20, 410-438 at 418 and 422, submitted in Professors Willmott and White, Directors, Australian Centre for Health Law and Research and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, JSCEOLC Submission 560.



*claiming that the patient's quality of life is so low that death is a better alternative. The inference is that it is not a life worth living, anyway. This way of emphasizing the sick person's limitations and reduced possibilities for an independent life is tantamount to dehumanization. It is the degradation of a human being into a sub-human object with a lower protection value, in order to make it easier to participate in the person's death.*<sup>268</sup>

- 2.100. Statements in support of assisted suicide for people with disabilities stand in direct contrast with those statements made by several prominent people living with disability on this issue:

*Whilst supporters of assisted suicide claim that the opposition of disabled people is irrelevant because these bills are only intended for terminally ill people, the top five reasons given by those using the Oregon assisted suicide law all relate to the experience of disability: "loss of autonomy" (91%), "less able to engage in activities" (89%), "loss of dignity" (81%), "loss of control of bodily functions" (50%) and "feelings of being a burden" (40%). Assisted suicide laws are at their core, about disability.*<sup>269</sup>

*Euthanasia concerns me greatly, especially because I have a disability. If legalised, people like myself will be vulnerable, especially as time goes on. People with disabilities or incurable illnesses will have to choose whether or not they want to be a burden on other people. Euthanasia will become normalised in our society and people like myself would be conditioned and pushed towards it. People who do not want to die will die. An ethical threshold is crossed if we legalise euthanasia. There will be people who society will say, "Their lives are worth living." And there will be those who society will believe are better off dead. Allowing people to legally end their life has consequences for our entire society.*<sup>270</sup>

*This fear of disability typically underlies assisted suicide. Janet Good, an assisted suicide advocate who worked with Jack Kevorkian, was clear about this: "Pain is not the main reason we want to die. It's the indignity. It's the inability to get out of bed or get onto the toilet. . . [People]. . . say, 'I can't stand my mother - my husband—wiping my*

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268 Stahle F (2017) 'Moral disengagement – Mechanisms Propelling the Euthanasia/PAS Movement,' *Journal of Ethics in Mental Health* 10 at 6.

269 Carr L (2017) 'It's about people like me: disabled and dead against euthanasia,' <<https://www.mercatornet.com/careful/view/its-about-people-like-me-disabled-and-dead-againsteuthanasia/20276>> quoted in Rev Dr Parkinson, Director, LJ Goody Bioethics Centre, JSCEOLC Submission 53 at 5.

270 Mr Byl, Private Citizen, JSCEOLC Transcript, 1 May 2018, Session 6 at 2.

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*butt". But as many thousands of people with disabilities who rely on personal assistance have learned, needing help is not undignified, and death is not better than reliance on assistance. Have we gotten to the point that we will abet suicides because people need help using the toilet?<sup>271</sup>*

*You have to see that at the very heart of [the New Zealand End of Life Choices Bill] is a primal fear of becoming disabled. To put it in the words of Baroness Jane Campbell (a disabled peer) "...society's view of terminal illness and [of] disability I think can be summed up in one word. That word is fear: fear of loss of opportunity; fear of denial of self determination; fear of loss of control; fear of pain; fear of hardship; fear of being a burden to others." Does that attitude of fear and diminution of disability that runs through society and is utterly embedded in the words of this bill offend me? Absolutely, and to the marrow of my bones ... And let's be very, very clear that there can be no protection, there can be no "safeguards," in a bill that starts with the implicit proposition that it is better to be dead than disabled. That's choice?<sup>272</sup>*

*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?" What we as a society think we know about what it means to live as a disabled person comes from cultural representations of disability seen through a nondisabled lens. And we, as people with disability, rarely get to tell our own stories.*

*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*

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271 Golden and Zoanni (2010) 'Killing Us Softly: The Dangers of Legalizing Assisted Suicide' *Disability and Health Journal* 3(1) 16-30 at 18.

272 Wendi Wicks, Not Dead Yet, 11 June 2018, Submission Against the New Zealand End of Life Choices Bill <<http://notdeadyet.org/2018/06/wendi-wicks-hard-hitting-oral-testimony-against-nz-end-of-life-choices-bill.html>>

*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.*

*Perhaps our discomfort with this kind of thing is why we don't hear the counter view in reports about assisted dying. Often we hear supporters of euthanasia and assisted suicide talk about wanting to avoid the pain and suffering that often comes with imminent death. But more often, we hear stories like Barbara Harling's, which are more about wanting to avoid a loss of autonomy and independence.<sup>273</sup>*

- 2.101. Vulnerable communities and individuals raise strong concerns that legalisation of assisted suicide leads to attitudinal changes, subtle biases about quality of life, and judgments that some lives are not worth living.<sup>274</sup> In relation to the construct of 'dignity,' Mr Randal of the Coalition for the Defence of Human Life writes

*We believe that the process of dying should never be characterised as "undignified." Natural death usually involves loss of appetite, fatigue, increased sleep, physical weakness, confusion, disorientation, social withdrawal, laboured breathing, loss of bodily control and so forth. This progressive decline is to be expected and nurses and doctors know how to deal compassionately with it. This is not an "undignified" death, any more than a woman giving birth to a child is undignified, or a person forced to wear a colostomy bag is undignified, or a quadriplegic*

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273 Stella Young, 'Disability - a fate worse than death?' *ABC Ramp Up*, 18 Oct 2013 <<http://www.abc.net.au/rampup/articles/2013/10/18/3872088.htm>>

274 Snyder, Sulmasy and Mueller (2017) 'Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper,' Professionalism and Human Rights Committee of the American College of Physicians, *Annals of Int Med* 167(8) 576.

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*requiring someone to look after his/her bodily needs is undignified. On the contrary, caring for the terminally ill through the final stages of their lives demonstrates our society's care, compassion, commitment and respect for the dying. It is our view that deliberately killing a human being with a lethal injection, or by any other means—is truly undignified.*<sup>275</sup>

- 2.102. Mrs Esther Humble, a speech pathologist working with people with disability, also raised a significant concern about the message that the legalisation of assisted suicide sends in relation to dignity, disability and quality of life, and the impact on social perception of disability:

*My third concern is that if laws such as this are implemented, the perceptions of society of disability will worsen. I read some submissions by some senior citizens who do not have terminal illness, but are requesting euthanasia to be an option to them because they are concerned about the unknown; they are concerned that if in the future, "I lose my mental or physical abilities, if I become dependent on others, cannot control my bodily fluids, then I would please not like to live anymore." However, essentially they are saying that it is untenable for them to live in a way that people with disability often live every day. This sends a message to society that living in such a way, as is often the lifestyle for people with disabilities, is a poor quality of life, cannot be enjoyed and is not worth living. I think this sends a very negative message to people with disabilities who live like this, many who claim to have a good quality of life.*<sup>276</sup>

- 2.103. Professors Willmott and White, proponents of assisted suicide, argue that the state has an interest in preserving the life of a healthy and well person, but that this interest falls away when a person has a medical condition that will cause their death.<sup>277</sup> Ms Re of IdentityWA responds:

*This statement seems to assume that, at a particular point, the state should "lose interest" in the preservation of persons who have been diagnosed with a terminal medical condition. The statement is framed in such a way as to assume that the value of persons who have been*

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275 Mr Randal, President, Coalition for the Defence of Human Life, Presentation to the Select Committee on End of Life Choices, submitted in JSCEOLC Response to Questions on Notice, 17 April 2018 at 3.

276 Mrs Humble, Private Citizen, JSCEOLC Transcript, 5 April 2018, Session 2 at 2-3.

277 Willmott and White (2017) 'Assisted Dying in Australia: A Values-based Model for Reform' in *Tensions and Traumas in Health Law* at 502-3, submitted in Professors Willmott and White, Directors, Australian Centre for Health Law and Research and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, JSCEOLC Submission 560A.

*diagnosed with a terminal medical condition is somehow less than those who do not have such a condition.*

*We believe that such a statement is contrary to much of what is held as central both in the caring professions, and in our WA society more broadly... Our experience is far from [Professors Willmott and White's] suggestion that life nearing its end is somehow less valuable. On the contrary, our experience has been that life becomes all the more precious. This has left us with the view that non-abandonment and considerate care is one of the hallmarks of the success of our work, and indeed of our society.*

*The state certainly has an interest in this. If it did not, why would so much energy, effort, attention, and funding be put towards the question of what constitutes best practice end of life care?<sup>278</sup>*

- 2.104. Any legalisation of assisted suicide would also occur 'within the context of a health care system and a society pervaded with prejudice and discrimination against people with disabilities.' Already, this prejudice and discrimination play out in life-threatening ways, including pressure by hospital staff on people with disabilities who are nowhere near death to sign 'Do Not Resuscitate' orders and reject life-sustaining treatment.<sup>279</sup> Evidence was given to the Committee about the discrimination and inequity of access to health care that people with disabilities experience in this State. Mrs Gaye Matthews, the mother of, and carer for, Carissa Matthews who lived with a disability, said 'I very much feel that if we had just left Carissa in hospital, they would have suspended treatment.'<sup>280</sup> Ms Re also gave evidence that

*We have had occasions that people in our care have been unwell—for example, had a really bad cough or bronchitis or whatever—and have been taken to an emergency department, and this has happened more than once. Then there has been a discussion that the treatment would be a course of antibiotics and did we want the person to be treated. I guess when that happens, the question is really: why would that discussion need to take place in the first place? If that was an able-bodied person, if that was someone fit and healthy and whatever else, there would be no question about that. That does not happen all the time, but it does happen. Gaye's comment about the way that people*

278 Ms Re, Chief Executive Officer, IdentityWA, JSCEOLC Response to Questions on Notice, 10 April 2018 at 1.

279 Golden and Zoanni (2010) 'Killing Us Softly: The Dangers of Legalizing Assisted Suicide,' *Disability and Health Journal* 3(1) 16-30 at 18, quoting Longmore P. 'The resistance: the disability rights movement and assisted suicide,' in Longmore P, ed. *Why I burned my book and other essays on disability* (2003) Philadelphia: Temple University Press at 175-203.

280 Mrs Matthews, Individual Submitter, JSCEOLC Transcript, 27 February 2018, Session 3 at 5.

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*are viewed in terms of the quality of their existence and how they are valued as individuals is something that is of great concern to us. People with disabilities, particularly people with severe disabilities, both intellectual and physical disabilities, most certainly are devalued by our society and there can be, on occasion, a different set of rules that apply.*<sup>281</sup>

- 2.105. Mrs Matthews also gave evidence to the Committee that ‘Sadly we had to fight/demand palliative care which was far more than the “just take her home” response of the consultant in the hospital.’<sup>282</sup>
- 2.106. In light of the inequitable access to health care in Western Australia, including inequitable access to palliative care services, it is clear that assisted suicide would not promote choice for people living with disabilities in this State:

*[People with disabilities] already experience a lot of difficulty in accessing basic healthcare and community services. Should it be that euthanasia is an easier option for them to access than basic health care, that would be very, very wrong. That is a concern by disability advocates such as Craig Wallace, who says that until people with disability are able to access the same level of community services and health care and have access to the same choices of health care, then euthanasia is a poor choice that should not be offered. Would it be right to have easier access to euthanasia than to proper dental care? That would be wrong, and also these things put people with disability at higher risk of experiencing suffering considered to be intolerable. It is how society relates to them.*

...

*Also, we do know that people with disability experience high levels of abuse and all these factors can lead to them becoming more vulnerable, I would say, to choosing an option which might be because there are limited options rather than because that is the best option for them.*<sup>283</sup>

- 2.107. The idea that the availability of assisted suicide presents a choice for those who would like it is challenged by disability rights advocates, who suggest that inequitable access to health care for disabled people renders that choice illusory:

*[T]he idea of choice ... is a sad shabby figment. You need to keep in mind that choice - an underpinning of [assisted suicide legislation] - will be, to*

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281 Ms Re, Chief Executive Officer, IdentityWA, JSCEOLC Transcript, 27 February 2018, Session 3 at 6.

282 Mrs Matthews, Individual Submitter, JSCEOLC Response to Questions on Notice, undated.

283 Mrs Humble, Private Citizen, JSCEOLC Transcript, 5 April 2018, Session 2 at 1-2.

*disabled people, like the choice poorer people have in supermarkets- a choice with fewer options; a choice with more illusions than equality.*<sup>284</sup>

- 2.108. Assisted suicide proposals usually would require two doctors to agree to a person's request for a prescription for a lethal dose to be used to end the person's life. To do so the doctors essentially need to agree that the person would 'be better off dead' or at least that it is reasonable for a person in that position to consider that he or she would be better off dead.<sup>285</sup> Legalised assisted suicide therefore threatens to create a 'two-tiered system' where non-disabled individuals who express suicidal wishes will receive suicide prevention services, while individuals with disabilities will receive lethal prescriptions, resulting in 'death to the socially devalued group.'<sup>286</sup>
- 2.109. As outlined earlier in this Report, doctors are also less likely to identify depression in people with disability, simply by assuming that it is normal for a person with a disability to show signs of depression such as sadness and a 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' or that 'life is too hard.'<sup>287</sup>
- 2.110. The risk that assisted suicide presents to people with disability in the context of this approach by health professionals, particularly following an initial diagnosis of a condition that may involve a considerable level of disability, is made clear in the following account:

*This approach poses a severe risk to people following an initial acquisition or diagnosis of a condition that may involve a considerable level of disability. 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. 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*

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284 Wendi Wicks, Not Dead Yet, Submission Against the New Zealand End of Life Choices Bill, 11 June 2018 <<http://notdeadyet.org/2018/06/wendi-wicks-hard-hitting-oral-testimony-against-nz-end-of-life-choices-bill.html>>

285 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 27.

286 Golden and Zoanni (2010) 'Killing Us Softly: The Dangers of Legalizing Assisted Suicide' *Disability and Health Journal* 3(1) 16-30 at 18.

287 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 29.

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*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. How many such individuals is our society prepared to sacrifice as the collateral damage from the legalization of assisted suicide?*<sup>288</sup>

- 2.111. The State Government's interest in preserving the life of all its citizens, regardless of their medical condition or disability, should be a priority of the highest order. The Government should make active and sustained efforts to provide equitable access for disabled people to quality health care in Western Australia, including the highest standard of palliative care, which is currently lacking. Any Government initiative should support people living with disabilities in Western Australia to be able to make choices in their living with the care and health services that they need.

### **Finding 34**

Assisted suicide laws are, at their core, about disability.

### **Finding 35**

Assisted suicide laws enshrine a negative message about living with a disability.

### **Finding 36**

There can be no protection or safeguard in any law that begins with the implicit proposition that it is better for some people to be dead than disabled.

### **Finding 37**

People with disabilities experience discrimination and inequity of access to health care in Western Australia.

### **Recommendation 9**

The Minister for Disability Services should develop a plan, in consultation with people with disabilities, carers, the Minister for Health and health practitioners, to deliver equitable access to health care in Western Australia.

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288 Ibid, citing M Golden, 'Why assisted suicide must not be legalized,' Disability Rights Education and Defense Fund <<https://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/>>



**Finding 38**

An assisted suicide regime threatens to create a two-tiered system where individuals without a disability who express that they wish to end their life are referred to suicide prevention services, while individuals with disabilities who express that they wish to end their life are referred for lethal prescriptions.

**Assisted Suicide and Suicide Prevention****An artificial distinction between ‘rational’ suicide and suicide generally**

- 2.112. Proponents of assisted suicide, or what they would prefer termed ‘assisted dying,’ construct a distinction between rational suicide (assisted suicide) and suicide generally. ‘Assisted deaths’ are said to be a choice between two different ways of dying, unlike general suicide, where the choice is between living and dying.<sup>289</sup>
- 2.113. Dr Elizabeth Moore, Chair of the RANZCP, drew a distinction between the two in evidence to the Committee: ‘When a person is not expected to live for a certain amount of time, that they have unbearable pain or suffering, I think this is a very different scenario from actually saying that the person wants to suicide in the parlance that we are now talking about suicide prevention.’<sup>290</sup>
- 2.114. The irony of this distinction was raised by former Attorney General Hon Michael Mischin in the Legislative Council in debate about the terms of reference of the Joint Select Committee on End of Life Choices. He argued:

*It is ironic when it is suggested that somehow the issue of suicide generally is entirely different from the issue of a medical diagnosis leading to a desire to put oneself out of one’s misery because, in every case reported in the newspaper of late in which this issue has been raised and people have talked about their experiences and why they would like to be able to be assisted to kill themselves, a little line is routinely put at the bottom of the article that states: if you or anyone else is considering suicide, please contact X helpline. It is not by any means a totally different issue; it is germane to this issue. It is an issue that I think members of the community concerned about where the lines are drawn would need us to ensure that this committee, if it does express a wide variety of views, will look into and decide on.’<sup>291</sup>*

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289 Mr Wood, Christians Supporting Choice for Voluntary Euthanasia, JSCEOLC Transcript, 13 April 2018, Session 3 at 2.

290 Dr Moore, Branch Chair, Royal Australian and New Zealand College of Psychiatrists (WA), JSCEOLC Transcript, 28 February 2018, Session 5 at 6.

291 Hon Michael Mischin, *Hansard*, Legislative Council, 22 August 2017 at 3079.

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2.115. The RANZCP(WA) also recommended ensuring that support for carers and suicide prevention programs for older adults are adequately resourced and ironically considered that additional resources may be needed to provide support during the assisted suicide debate in Western Australia.<sup>292</sup>

2.116. In evidence given to the Committee, Dr Best articulated it in this way:

*When most people want to hasten death, we call it a psychiatric emergency and we worry about the rising rate of suicide in our country. Why are the terminally ill treated differently? Why isn't this a psychiatric emergency? The legalisation of euthanasia sends a message to our society that suicide is a legitimate solution for trouble in life.*<sup>293</sup>

2.117. Boudreau and Somerville suggest that to create a distinction between persons with a terminal illness and persons without a terminal illness is artificial and dishonours the terminal phase of a person's life:

*It is also pertinent to point out that Canada continues to fund and promote programs that aim to prevent suicide. If suicide is conferred the status of a right or is held to be acceptable medical treatment it would be difficult to reconcile this situation with the presence of programs that aim to actively thwart it. Some resolve this dilemma by trying to banish the word 'suicide' from the debate, in favor of the phrase 'assisted dying.' Marcia Angell, erstwhile editor of the NEJM and a fervent proponent of PAS, endorses the notion that 'assisted dying' can be distinguished from 'typical suicide.' The latter is described as being undertaken by someone with a normal life expectancy, whereas the former is carried out in someone 'who is near death from natural causes anyway.' They are going to die anyway, so what does it matter?! We believe that this reasoning is rather disingenuous and that it can result in a dishonouring of that segment remaining in someone's life, whether this is measured in minutes or months, and could deprive them of something as ephemeral as dreams and hopes. It certainly negates the idea of dying as our last great act of living.*<sup>294</sup>

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292 Royal Australian and New Zealand College of Psychiatrists (WA), JSCEOLC Submission 391 at 10.

293 Dr Best, Palliative Care Physician and Academic, JSCEOLC Transcript, 1 May 2018, Session 2 at 3.

294 Boudreau and Somerville (2013) 'Euthanasia is not medical treatment,' *British Medical Bulletin* 106, 45-66 at 62.

- 2.118. The Professionalism and Human Rights Committee of the American College of Physicians also very recently articulated that '[l]egalized physician-assisted suicide medicalises suicide.'<sup>295</sup>

### **Conflict with existing suicide prevention programs**

- 2.119. As already noted, Hon Michael Mischin MLC identified the presence of suicide prevention information in news articles in which assisted suicide is discussed. The World Health Organisation warns news media to '[a]void language which sensationalizes or normalizes suicide, or presents it as a solution to problems' and '[a]void explicit description of the method used in a completed or attempted suicide.'<sup>296</sup> Dr Best also recognised the conflict with suicide prevention strategies in her statement that the legalisation of euthanasia sends a message to our society that suicide is a legitimate solution for trouble in life (above). It follows that proponents of assisted suicide are out of step with World Health Organisation policies on suicide prevention.
- 2.120. Concern about the conflict between legalised assisted suicide and suicide prevention programs was a theme consistently raised in Committee evidence. Rev Dr Joseph Parkinson of the LJ Goody Bioethics Centre asks 'If all suicides are tragic, how can some suicides be considered good—and indeed, authorised by the State?'<sup>297</sup> Mr Paul Byl, a private citizen who gave evidence to the Committee about living with a disability, states 'Either society recognises that all life is valuable or we will not be able to find a good, fixed, unchallengeable reason to stop anyone from committing suicide.'<sup>298</sup>
- 2.121. In a response to the Committee's Questions on Notice, Ms Re gave detailed consideration to the question of autonomy and suicide raised by Professors Willmott and White in their own evidence to the Committee, and the contradiction that arises between suicide prevention programs and assisted suicide:

*In keeping with the social theory of individualism, [Professors Willmott and White] extend the definition of autonomy to self-determination which they hold involves having a person's will respected and acted upon. In other words, a person determines that what they want is suicide, and therefore they shall have it. Our position sees no conflict in "respecting" a person's will to suicide in the sense that this will is acknowledged. That is a basic premise of accompaniment. However,*

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295 Snyder, Sulmasy and Mueller (2017) 'Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper,' Professionalism and Human Rights Committee of the American College of Physicians, *Annals of Int Med* 167(8) 576.

296 World Health Organisation (2008) *Preventing Suicide: A Resource for Media Professionals*, Geneva, at 6, 7 and 8, cited in R Doerflinger, (2017) 'The Effect of Legalizing Assisted Suicide on Palliative Care and Suicide Rates: A Response to Compassion and Choices,' *On Point* 13 at 6.

297 Rev Dr Parkinson, Director, LJ Goody Bioethics Centre, JSCEOLC Submission 53 at 6.

298 Mr Byl, Private Citizen, JSCEOLC Transcript, 1 May 2018, Session 6 at 2.

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*[the Professors] erroneously equate the expression of autonomy (or self-determination) with its fulfilment, as in a person's will is to be "acted upon." Some pages later, [they] at least recognise that autonomy cannot be "unfettered," and that it is constrained by inter alia the value of life. We argue that this is the principle on which suicide prevention programs are based. The contradiction between these programs and assisted suicide is therefore readily apparent.*<sup>299</sup>

- 2.122. Rev Ashley Saunders, National Director of FamilyVoice Australia, suggests '[w]e cannot afford to send mixed messages about the value of life or about suicide. So in a sense giving in to a person, whether older or younger, when they are for one reason or another suffering and desiring to end their life, in my view is bad policy and actually is counterproductive.'<sup>300</sup> The inherent conflict in public policy between assisted suicide and suicide prevention was also raised by Mr Randal of the Coalition for the Defence of Human Life.<sup>301</sup>
- 2.123. Assisted suicide legislation creates 'an instrumental scale to determine who can be assisted with suicide and who is provided treatment for suicidal ideation.'<sup>302</sup> Mr Egan of Defend Human Life! articulates the issue in this way

*If you look at your state's suicide prevention study or framework ... the target is to tell everybody that there is a better way, that there is hope. An assisted suicide scheme wants to bracket off a whole category of people and say suicide prevention for most Western Australians, and suicide facilitation, by law, for some other Western Australians. How are you making that distinction? Of course, the broader your assisted suicide law that is passed, the more that distinction is sort of harder to sustain, and the messages that are then sent out to the community.*

...

*Members tried to press the Minister for Health on this in the Victorian Parliament: What is Lifeline going to be told? If someone calls up saying, "I'm feeling suicidal," do they first ask, "Well could I check whether you*

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299 Ms Re, Chief Executive Officer, IdentityWA, JSCEOLC Response to Questions on Notice, 10 April 2018 at 1-2.

300 Rev Saunders, National Director, FamilyVoice Australia, JSCEOLC Transcript, 9 March 2018, Session 3 at 4.

301 Mr Randal, President, Coalition for the Defence of Human Life, JSCEOLC Response to Questions on Notice, 17 April 2018 at 2.

302 'ACUF Senior Policy Fellow, and Senior Policy Fellow for the Centre for Human Dignity, Julie Hocker Testifies at the New York Assembly, New York Assembly Committee on Health, Public Hearing on Bill 2383-A,' 3 May 2018 – cited in Prof Margaret Somerville, Professor of Bioethics, University of Notre Dame Sydney, Supplementary Information provided to the JSCEOLC, 8 May 2018.

*have a diagnosis of a terminal illness that gives you less than six months to live; yes or no? If the answer is yes, let me refer you to the Western Australian government assisted suicide facilitation line.” ... Members of Parliament did try to probe this question in Victoria, but were certainly not to my mind given satisfactory answers, because we would be introducing a double standard.<sup>303</sup>*

- 2.124. It would be more logical and intellectually honest for a proponent of assisted suicide to take the position of Dr Nitschke, Exit International, or the position of Mr Silvan Luley and Mr Ludwig Minelli of Dignitas, Switzerland, that assisted suicide should be available for all:

*So all people qualify...including the depressed, the elderly bereaved, the troubled teen...we should not erect artificial barriers in the way of subgroups who don't meet our criteria.<sup>304</sup>*

*It is logic, from our point of view and our experience, because, quite simply, people who have a real choice and are professionally accompanied and are professionally counselled if they are a patient—it does not matter whether they are in a life crisis or whether they have terminal cancer—when they know they can turn to someone, maybe a physician, maybe an organisation like Dignitas, when they know they can talk openly about it... and get advice, then they are much less at risk to turn to violent methods. So the best—it might sound provocative, but our experience is that the best suicide prevention and suicide attempt prevention that you can have is if you give as far as possible access to assisted dying, because people then know they can access professional help and have a choice and thus they do not have to turn to violent methods.<sup>305</sup>*

- 2.125. In a study by Jones and Paton, comparing trends in suicide rates in US states that have legalised assisted suicide compared against those that have not, found that legalising assisted suicide was associated with a 6.3 per cent increase in total suicides (i.e. including assisted suicides). This effect was larger (14.5 per cent) in the over 65s age group. While not considered a significant increase, the introduction of legalised assisted suicide was

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303 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Transcript, 9 March 2018, Session 1 at 6 and 7.

304 Philip Nitschke in an interview with Kathryn Jean Lopez in the *National Review*, 5 June 2001 and quoted in *Hansard*, Standing Committee on Legal and Constitutional Affairs, 14 April 2008 at 43.

305 Mr Luley, Board Member, Dignitas, Switzerland, JSCEOLC Transcript, 8 March 2018, Session 5 at 7 (emphasis added).

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certainly not associated with a decline in non-assisted suicide rates.<sup>306</sup> The hypothesis that the legalisation of assisted suicide will reduce suicide rates does not hold.

- 2.126. In 2012, the age-adjusted suicide rate among Oregonians was 17.7 per 100,000, 42 per cent higher than the national average. The rate of suicide among Oregonians has been increasing since 2000. Suicide rates among adults aged 45-64 years rose more than 50 per cent from 18.1 per 100,000 in 2000 to 28.7 per 100,000 in 2012; the rate increased more among females than among males. This suicide rate data did not account for physician-assisted suicides under Oregon's *Death With Dignity Act*.<sup>307</sup>
- 2.127. The Coalition for the Defence of Human Life suggest that these figures indicate that the legalisation of assisted suicide sends the message that suicide is an appropriate and acceptable response to suffering, and normalises this most tragic of actions.<sup>308</sup>

### **The assisted suicide of Dr David Goodall**

- 2.128. The highly publicised assisted suicide of Dr David Goodall earlier this year raised some very concerning issues. Dr Goodall was quoted in news media as stating:

*My feeling is that an old person like myself should have full citizenship rights including the right of assisted suicide. Once a person is past the stage of middle life, one has paid back to society the debts that have been paid out. One should feel free to use the rest of his life as one chooses. If one chooses to kill oneself then that's fair enough. I don't think anyone else should interfere.*<sup>309</sup>

- 2.129. His assisted suicide in Switzerland came after repeated failed suicide attempts in the 12 months prior to his death.<sup>310</sup>
- 2.130. Dr Nitschke urged the Western Australian Parliament to consider the Swiss assisted suicide model that 'allows for a person to say, "Look, I've reached the end of my very productive life and now is the time to die. In other words, it's my right to have access to the best drugs."<sup>311</sup>
- 2.131. In contrast to the position of Dr Nitschke, Dr Michael Gannon (the then President of the AMA) expressed concern that the suicide of someone who is aged 100 was being

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306 Jones and Paton (2015) 'How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?' *Southern Medical Journal* 108 (2015) 599-604.

307 Shen and Millet (2015) *Suicides in Oregon: Trends and Associated Factors 2003-2012*, Oregon Health Authority, Portland, Oregon, at 3 and 7.

308 Mr Randal, President, Coalition for the Defence of Human Life, JSCEOLC Response to Questions on Notice, 17 April 2018 at 1.

309 Charlotte Hamlyn, '104-year-old academic David Goodall to travel to Switzerland for voluntary euthanasia' *ABC News*, 1 May 2018.

310 *Ibid.*

311 Dr Nitschke, Exit International, JSCEOLC Transcript, 13 April 2018, Session 1 at 3.

celebrated and wondered ‘What is the age at which we no longer celebrate people continuing with life?’<sup>312</sup> Dr Gannon also expressed concern with the reasoning Dr Goodall had expressed around his decision:

*People like Dr Goodall make a decision based on nothing more than they’ve decided there’s nothing more to live for. I think that’s a dangerous line to cross. I have serious concerns about a community where we make arbitrary decisions about whose life is valuable enough to continue and whose should be ended under the law. A society should aspire to look after people who are struggling and to make sure that their lives are worth living. We should aspire to better end-of-life care. We should aspire to better palliative care.*<sup>313</sup>

- 2.132. It is also important to note that Dr Goodall had recently experienced ageism in his workplace. The ABC reported in 2016 that after having worked for nearly two decades at the Edith Cowan University, Goodall was told to leave amid concerns about his well-being. The incident gained international media attention, with Goodall, then 102, calling it ageism in the workplace, and saying ‘It’s depressed me; it shows the effect of age. The question would not have arisen if I were not an old man.’<sup>314</sup>
- 2.133. After feeling that he was too old to actively participate in society, Dr Goodall was then farewelled by the Premier of Western Australia with the words ‘He’s a very, very old man and he’s obviously had enough. I feel for him and his circumstance and I wish him all the best in his last journey.’<sup>315</sup>
- 2.134. Calls for access to assisted suicide for the elderly were also made in evidence to the Committee. Ms Patricia Marshall, a private citizen and retired public servant, stated

*The questions of loss of self-autonomy and human dignity, conscious awareness of physical or mental deterioration and the realisation that meaningful participation in life has come to an end are very important considerations for the elderly and should be included in any discussion of end-of-life choices. The process of ageing brings an increasing awareness of one’s own deterioration and detachment from what is perceived as a complete life. It is only when this process is directly experienced that it can be fully understood; therefore, it is necessary for those making decisions to change the law to take some advice from*

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312 Philip Oltermann, ‘David Goodall, Australia’s oldest scientist, ends his own life aged 104’ *The Guardian*, 10 May 2018.

313 Charlotte Hamlyn and Brianna Shepherd, ‘David Goodall ends his life at 104 with a final powerful statement on euthanasia’ *ABC News*, 11 May 2018.

314 Lindsey Bever, ‘David Goodall, 104, just took his own life, after making a powerful statement about assisted death’ *The Washington Post*, 10 May 2018.

315 Dylan Caporn, ‘First-class for final journey’ *West Australian*, 3 May 2018 at 7.

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*those who may choose a voluntary and dignified end to their life when they perceive it to be complete.*

...

*[Y]ou get to an age where you have not got many more years left and you start to think, "I've done everything useful in my life that I'm ever going to do and I'm eking out the rest of my life on whatever small amount of capital I have been able to accumulate." Then there is ill health, and I think one does perceive one's own mental capacity deteriorating. When you start to think, "How much longer am I going to go on?" and then, "What will end when I can no longer control my bodily functions, my finances, my social life?"<sup>316</sup>*

- 2.135. Finding where to draw the line at who would be eligible to access assisted suicide proved more difficult however. Dr Goodall suggested access to people past the stage of middle life:

*Once one is past the stage of middle life, one has paid back to society the debts that have been paid out. One should be free to use the rest of his life as one chooses. If one chooses to kill oneself then that's fair enough. I don't think anyone else should interfere.<sup>317</sup>*

- 2.136. In evidence to the Committee, Mrs Kathleen Trendall, a senior citizen, suggested 'perhaps people over 90.'<sup>318</sup>
- 2.137. In response to the question 'Do you think there is a stage where you may not have that capacity [to voluntarily consent to assisted suicide]?' Mrs Marshall relied 'You might not, but of course, that is the point at which you have to go, isn't it?'<sup>319</sup>
- 2.138. In contrast to the comments made by Dr Gannon (above) that 'A society should aspire to look after people who are struggling and to make sure that their lives are worth living. We should aspire to better end-of-life care. We should aspire to better palliative care,' the following exchange took place

*Hon Dr SALLY TALBOT: I wondered if I could just ask you two other quick things. Sometimes when people talk about that trajectory into old age—advanced old age—it is described as a kind of increasing misery. So, you lose all your friends, you have just talked about your money dwindling;*

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316 Mrs Marshall, Retired Public Servant, Albany resident, JSCEOLC Transcript, 7 March 2018, Session 1 at 1 and 3.

317 Charlotte Hamlyn, 'Academic David Goodall turns 104 and his birthday wish is to die in peace' *ABC News*, 4 April 2018.

318 Mrs Trendall, Senior Citizen, JSCEOLC Transcript, 7 March 2018, Session 1 at 2.

319 Mrs Marshall, Retired Public Servant, JSCEOLC Transcript, 7 March 2018, Session 1 at 4.



*there is not much to live for. So the people who do not agree with you would say, "It is up to society to remove the misery. If we remove the misery, then these people won't want to die." Do you have any comments about that?*

*Mrs MARSHALL: Why? Why would you want to do that?*

*Mrs TRENDALL: I could not see society improving the financial position of very elderly people.*

*Mrs MARSHALL: Quite the reverse!*<sup>320</sup>

### **Older age suicide**

- 2.139. Calls for access to assisted suicide for the elderly are regularly joined with concerns about older adult suicide rates in the Australian population. For example, dying with dignity state that:

*It is also worthwhile noting Mr Denton's reference to data provided by the National Coronial Information System on the numbers and methods relating to elderly Australians taking their lives. These show "the dark reality" facing too many older Australians... On average, two octogenarians a week are killing themselves in this country. The most common method used is hanging.*<sup>321</sup>

- 2.140. However, concern was raised by RANZCP in evidence to the Committee that:

*Australia's oldest citizens, those aged 80 and above, are the age group most likely to die as a result of suicide (ABS, 2012). This has led to a misconception that suicide in older people is largely driven by suffering associated with chronic, debilitating or terminal illness, whereas the aetiology of suicide is complex and usually multifactorial.*<sup>322</sup>

- 2.141. RANZCP assert that it is imperative that the implementation of physician-assisted suicide be accompanied by stringent safeguards to ensure that older people considering suicide are not given access to assisted suicide, as well as an expansion of suicide prevention programs to target older persons.<sup>323</sup> They also gave evidence that there is a need for specialist older adult mental health expertise and services and that '[a] physician assisted

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320 Mrs Trendall, Senior Citizen, and Mrs Marshall, Retired Public Servant and Senior Citizen, JSCEOLC Transcript, 7 March 2018, Session 1 at 5.

321 Dying with Dignity (WA), JSCEOLC Submission 565 at 14.

322 Royal Australian and New Zealand College of Psychiatrists (WA), JSCEOLC Submission 391 at 5.

323 Ibid.

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suicide framework must take into consideration the under-diagnosis and under-treatment of depression and suicidality in older people.<sup>324</sup>

- 2.142. Rosenwax and McNamara have also identified that persons aged over 84 years are a group in the Australian population who are the least well-served by specialist palliative care.<sup>325</sup>

### **On becoming a society accepting of suicide**

- 2.143. Just as assisted suicide for the terminally ill is logically extended to the assisted suicide of the elderly who are 'tired of life,' as in the case of Dr Goodall, the acceptance of assisted suicide also changes the perception of suicide generally so that it is no longer seen as tragic, but as an understandable solution to a person's problems. This sentiment was reflected in the comments of Mrs Trendall in relation to the suicide of older people suffering elder abuse: 'My personal feeling is that the elderly, if they are being abused or coerced, would in fact be so disillusioned, particularly if this were family members, that they would actually welcome an end to their life.'<sup>326</sup>
- 2.144. It is also evidenced in this discussion had in a Committee hearing:

*Mr J.E. McGRATH: Further to that, if someone was in a relationship where they had a relationship that was not working and it was very stressful on one of the partners and it was affecting them mentally and they decided, "I don't think I need to be here anymore," do you think they should be given the right to end it?*

*Mr IRELAND: If the circumstance was simply what you have articulated, my answer would probably be no. These days, one can remove oneself from a relationship that is not working. As I said to you before, divorce back then was pretty well unheard of, or frowned upon at least. Today, relationships break up more often than they stay together—or as often as they stay together. I can understand someone who is in a relationship and who is being battered, being physically and mentally abused by their partner, wanting to take their own life—yes. But if it was merely a breakdown of the relationship in terms of two people finding it uncomfortable or intolerable to live with one another but there is no physical abuse and no mental abuse, then no, I would not agree with that at all.*

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324 Ibid.

325 Rosenwax and McNamara (2006) 'Who receives specialist palliative care in Western Australia – and who misses out,' *Palliat Med* 20(4) 439-45.

326 Mrs Trendall, Senior Citizen, JSCEOLC Transcript, 7 March 2018, Session 1 at 2.

*Hon NICK GOIRAN: But if there is physical abuse, it would be okay?*

*Mr IRELAND: Sorry?*

*Hon NICK GOIRAN: If there was physical abuse in a relationship, then it would be okay?*

*Mr IRELAND: I think if it was severe physical abuse, yes. I can understand women who are being physically abused by their partners, unless they see a way out of the relationship and unless they find opportunities to move out of the relationship without fear, I can understand someone taking their own life if they were being severely physically abused, yes.*

*Mr R.R. WHITBY: You are not suggesting, though, that the state sanction that?*

*Mr IRELAND: No, I am not suggesting that at all. All I am suggesting is that I can understand someone taking their life, but I understand it would be impossible to legislate for that. You have to place yourself in the shoes of the individual. Each one of us in that situation—if you are a male or a female, living in a situation where you are being battered or being abused sexually or physically and you found no way out of it, I could understand someone wanting to take their own life. Good grief! I think it would be, in some cases, a natural extension for some people who cannot find their way out of it.<sup>327</sup>*

- 2.145. Dr Khorshid also gave evidence to the Committee of an anecdote shared at an AMA symposium conducted by AMA(WA) on the issue of assisted suicide, and attended by Professor Theo Boer, formerly a proponent of suicide from the Netherlands. Dr Khorshid reported that:

*suicide is seen more and more in Dutch society as a reasonable way out of whatever your existential suffering is. [Professor Boer] gave a specific example of a suicide of a woman—he did not mention how it happened—in a particular area in the Netherlands in a big town. The paper in that town had a six-page spread on this young woman, from his point of view, almost celebrating the fact that she had taken this courageous decision to end her life through whatever suffering it was. I do not think he gave us the exact reason that she ended her life. That is just an example of how rather than regarding suicide as a tragedy,*

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<sup>327</sup> Mr Ireland, JSCEOLC Transcript, Session 3, 30 April 2018, pp5-6 (emphasis added).

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*which is our normal response, it was being seen as a reasonable option to get you out of the situation that you are in.*<sup>328</sup>

- 2.146. These comments reflect what had earlier been described by Mr Randall as the ‘certain logic that if the state sanctions suicide in some form or another, then, as the law has an educative function, suicide will be seen by the public as an acceptable thing to do in certain situations such as terrible pain, terminal illness and deep depression.’<sup>329</sup> That logic, Mr Randall suggested, leads inevitably to a question:

*If a person in intractable pain can receive state-sanctioned assistance to kill themselves, then why can't a person who experiences similar pain, or who is deeply distressed, determine to take measures to end their own life?*<sup>330</sup>

- 2.147. Suicide should never be considered an acceptable solution for challenging situations, or even extreme hardship, in an individual’s life. Suicide is always a tragic occurrence, hence our justified investment in suicide prevention programs.

### **Western Australian Coronial data on suicides**

- 2.148. Some proponents of assisted suicide assert that some suicides occur because palliative care is not an adequate treatment option for those people. Comment was made by the Committee Chair that ‘Submissions received by the Committee indicate that there are people in the community for whom palliative care is not an adequate treatment option, and they choose to take their own lives.’<sup>331</sup>
- 2.149. Coronial data was provided to the Committee on the suicides of 199 Western Australians from 2012 to 2017. Closer and proper consideration of the Coronial data supplied to the Committee does not support this statement.
- 2.150. Evidence that these individuals suicided because palliative care was not an adequate treatment option for them is not supported by the data. There is no reference in the data to the failure of palliative care, or whether these individuals either had accessed or even had access to palliative care services. The Coroner’s Report states:

*In some cases, the deceased suffered from both mental and physical conditions which may have contributed to their intentional self-harm. In some instances, it was difficult to determine if the mental or the physical condition made a more significant contribution to their intentional self-*

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328 Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 18 May 2018, Session 1 at 9-10.

329 Mr Randal, President, Coalition for the Defence of Human Life, JSCEOLC Response to Questions on Notice, 17 April 2018 at 2.

330 Ibid.

331 Ms Sanderson, JSCEOLC Chair, JSCEOLC Transcript, 13 December 2017, Session 1 at 17.

*harm based on the information provided within the attached documentation.*

*In addition, it should be noted that the inclusion of the reference to the deceased's physical condition is not standardised across coronial documentation. As such, in some cases, it was difficult to ascertain the extent to which the deceased's condition influenced their motivation to self-harm.*<sup>332</sup>

- 2.151. The Coronial report initially identified 240 cases of 'Intentional Self-Harm Fatalities of Persons with Terminal or Debilitating Conditions in Western Australia' over the five year period between 2012 and 2017. This number was reduced by the Coroner's office to 199, as 41 of those cases were revealed by manual review of the data to show no evidence of the deceased being diagnosed with a terminal or debilitating physical condition.
- 2.152. Of the 199 cases, review of the data suggests that in 42 of the cases the individual could be classed as suffering from a terminal condition, while 157 would be classified as debilitating conditions. Of the 42 cases where the individual's case may have been terminal, the limited information provided in these cases indicates that 27 of these cases were advanced, or in the terminal stages of that illness. Others may also have involved advanced or terminal illness, however, this cannot be ascertained from the limited data provided in the Coronial report. For example, in Case 134 the deceased was an adult male who suffered from a number of medical conditions, including bowel cancer which had been surgically treated earlier that year. In the weeks prior to his death, the deceased was suffering pain following recent colon surgery, which involved the removal of a colostomy bag. The deceased was being treated with medication for pain management, but remained anxious and depressed about his symptoms. For the purposes of examining the Coronial data, Case 134 has been included in the 42 cases of terminal conditions because of the diagnosis of bowel cancer, which can be a terminal condition. However, there is nothing in the report to suggest that this was a terminal condition in Case 134, or that the deceased was suffering from an advanced stage of that disease. In a similar way, in Case 198 the deceased was an older male who had a medical history of hypertension, prostate cancer, atypical pneumonia, cystoscopy and asthma. The deceased had experienced a recent decline in his eyesight which rendered him unable to watch television or see telephone numbers, and he had recently handed in his driving licence. For the purposes of examining the Coronial data, Case 198 is included in the 42 cases involving a terminal illness because the deceased's medical history included prostate cancer which can be a terminal illness. However once again, there is nothing in

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332 Coronial Report CR17-61.1, 'Intentional Self-Harm Fatalities of Persons with Terminal or Debilitating Conditions in Western Australia 2012-2017,' at 3, provided by Gary Cooper, Principal Registrar, Coroner's Court of Western Australia, JSCEOLC Response to Questions on Notice, 24 May 2018.

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the report to suggest that this was a terminal condition in Case 198, or that the deceased was suffering from an advanced stage of that disease.

- 2.153. Further, any suggestion that the debilitating conditions reported in the data evidence a need for legalised assisted suicide in Western Australia can only be done if one fails to consider the data in detail. Of what appears to be 157 cases that are non-terminal, some of the conditions in those cases include diabetes, ongoing pain from workplace and vehicle accidents, 'elbow pain' (Case 87), 'long term arthritis' (Case 107), 'recurrent back pain but was otherwise healthy' (Case 181), 'generally well but had begun to suffer incontinence and difficulty walking' (Case 236) and 'significant eye problems his whole life, but was otherwise well' (Case 239). These conditions are not indicative of 'people in the community for whom palliative care is not an adequate treatment option, and they choose to take their own lives.'
- 2.154. The incidence of mental conditions in those classified as suffering from a debilitating condition was also very high. 99 of the 157 cases evidenced some level of mental ill-health, including depression, suicidal ideation or previous suicide attempts, anxiety disorder or bipolar disorder. Further, information provided in the data also suggests, as the Coroner's report states, that 'it [is] difficult to ascertain the extent to which the deceased's condition influenced their motivation to self-harm.'<sup>333</sup> For example, information provided in the cases included financial and relationship problems, experience of sexual abuse as a child, imprisonment, criminal charges, unemployment, social isolation and a history of drug and alcohol abuse.
- 2.155. The multifactorial nature of suicide is also evident in the 42 cases that may be classed as terminal. Fifteen of those cases included information relating to current or past mental ill-health (including diagnosis and treatment of depression) or previous suicide attempts. Equally, it is not possible to draw an inference of good mental health from the absence of information in the Coronial data on the mental state of the other 27 individuals who may have had an advanced terminal condition. To suggest that palliative care was not an adequate treatment option and therefore that they chose to take their own lives fails to take into account the full set of circumstances operating in that person's life at the time of their death. For example, Case 92, was an 'older male who died as a result of a self-inflicted gunshot wound.' He had 'progressive terminal cancer and was in constant pain and discomfort. He lived alone in a makeshift residence.'<sup>334</sup> Case 205 had 'end stage alcoholic liver disease and Zieve's syndrome' and 'two days before his death the

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333 Coronial Report CR17-61.1, 'Intentional Self-Harm Fatalities of Persons with Terminal or Debilitating Conditions in Western Australia 2012-2017,' at 3, provided by Gary Cooper, Principal Registrar, Coroner's Court of Western Australia, JSCEOLC Response to Questions on Notice, 24 May 2018 at 4.

334 Coronial Report CR17-61.1, 'Intentional Self-Harm Fatalities of Persons with Terminal or Debilitating Conditions in Western Australia 2012-2017,' at 3, provided by Gary Cooper, Principal Registrar, Coroner's Court of Western Australia, JSCEOLC Response to Questions on Notice, 24 May 2018, Case 92.

deceased was evicted from his home and was conveyed to hospital after ambulance officers responded to a mental health alert.<sup>335</sup>

- 2.156. It should be noted that of the 42 cases that may be classed as terminal, seven of these cases referred to the individual having been a member of a euthanasia organisation, or having researched euthanasia prior to their death.<sup>336</sup> Of these seven deaths, there is no information provided in the Coronial data whether these individuals had received palliative care, whether these individuals had access to the palliative care services they needed, or whether palliative care they had received was an inadequate treatment option for them.
- 2.157. It is agreed that these are 'brutal, lonely deaths that leave ineradicable scars in the families and first responders left to pick up the pieces.'<sup>337</sup> However, this data provided by the WA Coroner does not support the assertion that 'the prohibition of peaceful, doctor-assisted death drives some terminally ill individuals to suicide using violent and undignified means.'<sup>338</sup>
- 2.158. In light of the complexity that the Coronial data reveals, any suggestion that nothing could be done in any of these 199 cases other than the offering of assisted suicide is an appalling and defeatist proposition.
- 2.159. In the words of Rev Peter Abetz, WA State Director of the Australian Christian Lobby, 'I think we can do much, much better as a community than just to offer a less messy suicide.'<sup>339</sup>

### Finding 39

An assisted suicide regime in Western Australia would send a message that suicide is a legitimate solution in certain circumstances.

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335 Coronial Report CR17-61.1, 'Intentional Self-Harm Fatalities of Persons with Terminal or Debilitating Conditions in Western Australia 2012-2017,' at 3, provided by Gary Cooper, Principal Registrar, Coroner's Court of Western Australia, JSCEOLC Response to Questions on Notice, 24 May 2018, Case 205.

336 Cases 25, 59, 71, 83, 98, 147 and 204 in Coronial Report CR17-61.1, 'Intentional Self-Harm Fatalities of Persons with Terminal or Debilitating Conditions in Western Australia 2012-2017,' at 3, provided by Gary Cooper, Principal Registrar, Coroner's Court of Western Australia, JSCEOLC Response to Questions on Notice, 24 May 2018.

337 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 6.

338 Mr Francis, Dying for Choice Submission 642 at 12.

339 Rev Abetz, WA State Director, Australian Christian Lobby, JSCEOLC Transcript, 9 March 2018, Session 2 at 8.

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### **Finding 40**

Some proponents of assisted suicide endeavour to resolve the dilemma of inconsistency on suicide prevention by banishing the word 'suicide' from the debate in favour of the phrase 'assisted dying.'

### **Finding 41**

The highly publicised case of Dr David Goodall involved circumstances of overt ageism, troubling signs of suicide celebration and a seeming absence of any suicide prevention measures at work.

### **Finding 42**

The suicide rates in people aged 80 and above is a particular concern in Western Australia.

### **Finding 43**

The reason for older age suicide is complex and usually multifactorial, and should not be confused with the misconception that such suicides are driven by suffering associated with chronic, debilitating or terminal illness.

### **Recommendation 10**

The Minister for Mental Health, in consultation with the Minister for Seniors and Ageing, should expand suicide prevention programs to further target older Western Australians.

### **Recommendation 11**

The Minister for Mental Health should direct the Mental Health Commission to conduct an urgent review, outside and separate to any other general review processes underway, into the effectiveness of Western Australia's current suicide prevention strategies and programs in light of the Dr David Goodall case.

### **Finding 44**

Coronial data identified the suicide of 199 Western Australians with a terminal or debilitating condition between 2012 and 2017. Examination of the data reveals that 42 may be capable of being classified as suffering from a terminal condition and 157 with a debilitating one. Of the 42 cases, 27 can be identified as being in the advanced or terminal stage of illness. Of the 157 cases, 99 evidenced some level of mental ill-health.

### **Finding 45**

A close and proper examination of the coronial data of suicides between 2012 and 2017 does not support the assertion that individuals suicide because palliative care is not an adequate treatment option, but rather confirms the multifactorial nature of suicide.



## Assisted Suicide and the Medical Profession

### Assisted suicide fundamentally alters the role of the medical profession

- 2.160. The World Medical Association, in its Resolution on Euthanasia:

*reaffirms its strong belief that euthanasia is in conflict with basic ethical principles of medical practice, and strongly encourages all national medical associations and physicians to refrain from participating in euthanasia, even if national law allows it or decriminalizes it under certain conditions.*<sup>340</sup>

- 2.161. The American College of Physicians also state that the practice of assisted suicide:

*is problematic given the nature of the patient-physician relationship, affects trust in the relationship as well as in the profession, and fundamentally alters the medical profession's role in society... Control over the manner and timing of a person's death has not been and should not be a goal of medicine.*<sup>341</sup>

- 2.162. Indeed, the American College of Physicians question whether assisted suicide is a type of control over suffering and the dying process that is even within the goals and scope of medicine.<sup>342</sup>

- 2.163. Mrs Suzanne Greenwood, Chief Executive of Catholic Health Australia said, in evidence to the Committee:

*On... the question of clinical erosion, it is very much that the role of the clinician is to assist and help a person. To come to the conclusion that assisting and helping a person to remove their pain is to remove the person is just something that is not palatable to us.*<sup>343</sup>

- 2.164. Mr Tim Hammond, former Federal Labor MP, expressed the change this way:

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340 World Medical Association (2017) *WMA Resolution on Euthanasia* <<https://www.wma.net/policies-post/wma-resolution-on-euthanasia/>> quoted in Mr Randal, President, Coalition for the Defence of Human Life, Presentation to the Select Committee on End of Life Choices included in JSCEOLC Response to Questions on Notice, 17 April 2018 at 1-2.

341 Snyder, Sulmasy and Mueller (2017) 'Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper,' Professionalism and Human Rights Committee of the American College of Physicians, *Annals of Int Med* 167(8) 576, quoted in Rev Dr Parkinson, Director, LJ Goody Bioethics Centre, JSCEOLC Submission 53 at 7.

342 Snyder, Sulmasy and Mueller (2017) 'Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper,' Professionalism and Human Rights Committee of the American College of Physicians, *Annals of Int Med* 167(8) 576.

343 Mrs Greenwood, Chief Executive, Catholic Health Australia, JSCEOLC Transcript, 28 February 2018, Session 1 at 8.

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*And as legislators, let's be very clear-eyed in what we would be doing if we were to vote for such a law. As Paul Keating has said—“(it) means permitting physicians to intentionally kill patients or assisting patients in killing themselves.”<sup>344</sup>*

- 2.165. Offence is taken by proponents of euthanasia to the use of the word ‘killing’ when applied to the administration of assisted suicide by a medical practitioner. Their preference is for terms such as voluntary assisted euthanasia or assisted death. That the line drawn between assisted death and killing is a tenuous one is revealed in the following exchange between Dr Roger Hunt, a palliative care practitioner and advocate of assisted suicide, and Professor Margaret Somerville, provided in evidence to the Committee:

*I was speaking here in Australia several years ago and I said that we cannot have doctors killing people. A friend of mine who is also palliative physician and one of the rare ones who approves of euthanasia, Dr Roger Hunt, jumped up in the audience and said, “Margo, would you stop using that word ‘killing’? It is not killing.” I said, “What is it?” and he said, “It’s VAE.” I asked him what that stood for and he said voluntary assisted euthanasia. I went on in the speech and I made the suggestion that if we do it, let us keep it out of medicine, and who should it be, and I said lawyers. Roger rose to his feet and yelled out across the audience and said, “Margo, are you crazy? You would have lawyers killing people?” So when it was lawyers, it was seen as what it was; when it was doctors, it was not. That is because people find it very hard to believe that a doctor would do anything that was not ethical and entirely within their own, and just their own, best interests. We know that from what is called the “therapeutic misconception syndrome” in research—medical research. Even when you give a full explanation that this research will be of no benefit to you, when you go back and interview those people who were in the research study, they say things such as, “I really think this has helped me,” and you have already told them that it is not going to do that. So people trust doctors, and that trust is enormously important. You have to have trust in the medical institution, and that is also involved here.<sup>345</sup>*

- 2.166. The conflict between a doctor’s duty to protect the welfare of their patient and the practice of assisted suicide is clearly explained by Dr William Toffler, Professor Emeritus

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344 Tim Hammond, ‘Euthanasia and why I’m against it’ *PerthNow*, 3 December 2017.

345 Prof Somerville, Professor of Bioethics, University of Notre Dame Sydney, JSCEOLC Transcript, 1 May 2018, Session 8 at 5.

of the Department of Family Medicine, Oregon Health and Science University in the following statement:

*My job as a doctor is to alleviate their suffering, it's not to be a vending machine when they make a good 'rational' argument that they'd be better off dead. It's like being a lawyer for the defence and a lawyer for the prosecution in the same courtroom. Am I arguing for their health and wellbeing, to extend life as long as is reasonable, or am I advocating for their early demise because after all they are going to die anyhow? And then by the way, if you don't think that's a conflict of interest, I am also the judge to decide which argument is the best. And if you are not bothered by that, I am also the executioner. There are about 200 doctors in the State of Oregon who believe they can keep all that conflict of interest straight. It's a delusion.<sup>346</sup>*

### **The medicalisation of death**

- 2.167. It can be argued that making physicians the arbiters of assisted suicide is a return to paternalism and not a power physicians should want, that in fact the legalisation of assisted suicide does not empower the patient, but rather empowers the physician.<sup>347</sup>
- 2.168. The Professionalism and Human Rights Committee of the American College of Physicians write that:

*The suffering of dying patients may be great and is caused by somatic symptoms, such as pain and nausea; psychological conditions, such as depression or anxiety; interpersonal suffering due to dependency or unresolved conflict; or existential suffering based in hopelessness, indignity, or the belief that one's life has ended in a biographical sense but has not yet ended biologically. For some patients, a sense of control over the manner and timing of death brings comfort. However, is it reasonable to ask medicine to relieve all human suffering? Just as medicine cannot eliminate death, medicine cannot relieve all human suffering.*

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346 Dr William L Toffler, Professor Emeritus, Department of Family Medicine, Oregon Health and Science University, interviewed in Kevin Dunn (2018) *Fatal Flaws: Legalizing Assisted Death*.

347 Snyder, Sulmasy and Mueller (2017) 'Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper,' Professionalism and Human Rights Committee of the American College of Physicians, *Annals of Int Med* 167(8) 576.

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*Society's goal should be to make dying less, not more, medical. Physician-assisted suicide is neither a therapy nor a solution to difficult questions raised at the end of life.*<sup>348</sup>

- 2.169. That this power would be placed in the hands of medical professionals was also evident in the concerns expressed to the Committee by palliative care service provider Silver Chain, who were clear that assisted suicide is not a part of palliative care provision and that were it to be considered so, patients would fear the intentional ending of their life if assisted suicide were part of Silver Chain's care service:

*Hon NICK GOIRAN: So are you concerned that if Silver Chain were to provide assisted suicide, it would put off clients from accessing Silver Chain in the first place?*

*Mr COCKAYNE: For a part of the community it may, you know. If Silver Chain was providing that service directly, then some people may connect dots and infer that actually that is what you might do, irrespective of what my wishes are.*<sup>349</sup>

- 2.170. Similar concerns were expressed by Dr Alison Parr, Director of Medical Services, St John of God Health Care and Palliative Care Consultant:

*I think one of the big challenges with palliative care is the fear. When people initially hear about a referral to palliative care, for example, we spend a lot of time with those first contacts with patients and families just actually providing reassurance about what we are there to do. For some people, there is a fear that actually what we are there to do is end their life. To be able to currently say to them, "Look, we're here and we're all about living, actually. Until you die, it is not about assisting you to die and we're not about to do anything that is likely to shorten your life" often helps to build trust and allows people to open up in their most vulnerable times and talk very openly about their thoughts and fears. I guess there is potential in that situation to not be able to offer that level of reassurance and for people then to be even more wary of accessing services that might help them. That would potentially be a concern.*<sup>350</sup>

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348 Ibid at 577 and 578.

349 Mr Cockayne, General Manager, Health Care WA, Silver Chain Group, JSCEOLC Transcript, 15 December 2017, Session 3 at 14.

350 Dr Parr, Director, Medical Services, St John of God Health Care and Palliative Medicine Consultant, JSCEOLC Transcript, 28 February 2018, Session 1 at 8.

### **The false assertion that assisted suicide is only about patients and not their doctors**

- 2.171. To counter the awkwardness that legalised assisted suicide medicalises death, proponents assert that assisted suicide has nothing to do with doctors, and has everything to do with the autonomous patient. This assertion is seen in Go Gentle Australia's submission to the Committee, where Mr Denton writes that '[o]nly one person is being asked to make a life and death decision. Not the doctor. The person who is dying,' in support of a physician-assisted suicide model like that recently adopted in Victoria.<sup>351</sup> He states:

*This is not a law for doctors, even though, importantly, a law like this will protect doctors in a way they are currently not protected, should they assist a patient to die. This is a law for patients and I think in this conversation, the patient's voice, the patient's right to have a choice, the patient's right to determine that inevitable and most crucial thing in life, which is how we die, is overlooked and too often we look at this with the framework of: how do doctors feel about it? And part of what I have been trying to do over the last three years is tip the balance back to, "Wait a minute, this is actually about how we die, not about how doctors feel about how we die."<sup>352</sup>*

- 2.172. Dr Syme also gave evidence to the Committee about the centrality of the patient in the control offered by patient-administered lethal medication:

*I am absolutely convinced that self-administration is the appropriate thing for a number of reasons, but principally because that places control over the end of life firmly and totally in the hands of the individual... What is more, I would suggest to you that the responsibility for this action should lie with the individual. I as a doctor—my responsibility is to try to help you to go as far with your life as I possibly can. But if you feel you can go no further, I have a responsibility to help you to have a peaceful death. If you want to end your life, that is your responsibility. If you want to end your life, it is your responsibility to take that action if you are physically capable of doing so. It is not proper, in my opinion, for you to think that you can pass that responsibility to me. It is the greatest safeguard that you can have in legislation to put the onus on the individual if they want to end their own life because of their*

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351 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 43.

352 Mr Denton, Go Gentle Australia, JSCEOLC Transcript, 13 April 2018, Session 6 at 6.

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*intolerable suffering, and that is their responsibility and the safeguard is that they have to do it themselves.*<sup>353</sup>

- 2.173. As did Mr Murray Hindle, President of Dying with Dignity (WA):

*a drug that the individual can get after meeting the criteria and then take it themselves is by far the best option. It then takes away “the doctor’s a killer” sort of attitude that seems to be rife, and the person is able to do it themselves. Even if a doctor does help, he is really only facilitating the person to take their own life. I suppose it depends on how you look at it, but giving an assistance, handing a person the drug or at least giving it to them because they cannot handle it themselves, I really do not see that as killing them.*<sup>354</sup>

- 2.174. Stahle suggests that this is a deliberate transference of responsibility for the act onto the patient in order to lower the threshold to allow legalisation:

*In an assisted suicide, it is also the patient himself/herself who has to take the death drug. By way of this arrangement, one is able to transfer the responsibility for the act to the patient. This effectively lowers the threshold for legalization. It becomes more palatable for the doctor than to give a lethal injection, and the doctor does not even need (in Oregon) [and under the Victorian legislation] to be present when the patient takes the death drug... That the doctor “only” prescribes the poison and the patient himself/herself takes it is an example of diffusing responsibility. One can argue that the prescription in itself is harmless. However, with the prescription, a deadly substance is made available and the patient is recommended to use it. Furthermore, the physician consults with another physician. That is presented as a safety measure for the patient, but at the same time it means that they together take the decision to approve the patient’s request, which is another example of diffusing responsibility. All the parties involved can then distance themselves from their personal moral responsibility. In Oregon, they are also completely exonerated from all legal responsibility through the “good faith” rule that protects all the participants.*<sup>355</sup>

- 2.175. Mr Denton’s assertion that it is only the patient who makes a life and death decision is contradicted by Dr Nitschke, a fellow assisted suicide proponent, who in evidence to the

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353 Dr Syme, Medical Practitioner and Vice President of Dying With Dignity Victoria, JSCEOLC Transcript, 13 April 2018, Session 4 at 10.

354 Mr Hindle, President, Dying with Dignity (WA), JSCEOLC Transcript, 13 April 2018, Session 5 at 6.

355 Stahle F (2017) ‘Moral disengagement – Mechanisms Propelling the Euthanasia/PAS Movement,’ *Journal of Ethics in Mental Health* 10 at 5-6.

Committee stated that '[i]nvariably it comes back down to the medical profession who act as judge here and effectively decide if a person gets the right to die, whether they qualified to die or not. That is not a position that fits very comfortably with many medical professionals.'<sup>356</sup>

- 2.176. Mr Perron's criticism that 'it is all about access to the keys to the medicine cabinet. In that cabinet the government keeps the means to die a peaceful, tranquil death, but the law says you are not allowed to have any,'<sup>357</sup> is ironically answered by Dr Syme, who states that '[the doctor] is critically important to the individual's being fully informed and is the key to a dignified death.'<sup>358</sup>
- 2.177. Furthermore, directly contradicting his own assertion that assisted suicide has nothing to do with doctors, in his submission Mr Denton writes that 'the second major safeguard [of legislated assisted suicide] is the conservatism of the medical profession.'<sup>359</sup> On the one hand, assisted dying has nothing to do with doctors, but on the other hand, the doctor is central to the safeguarding against abuse. This anomaly is considered further later in this Report in the section entitled "*A safeguard is only as good as the doctor enforcing it.*"

### **The question of whether assisted suicide should be administered by a profession outside of the medical profession**

- 2.178. Since the introduction of assisted suicide would fundamentally alter the role of the medical profession and with it the doctor-patient relationship, it has been suggested that an entirely separate group of professional people should be trained to administer the program.<sup>360</sup> The AMA note that there is a lot of sympathy within parts of the medical profession for the idea that someone else other than medical professionals should be administering assisted suicide because the act of assisted suicide is not considered to be a medical act.<sup>361</sup> This was also confirmed by Mr John McGrath, Committee member, who said that this idea was raised in discussion he had with a surgeon who confirmed that many doctors do not want to be involved in assisted suicide and would prefer for the program to operate outside the medical profession.<sup>362</sup>

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356 Dr Nitschke, Exit International, JSCEOLC Transcript, 13 April 2018, Session 1 at 2.

357 Mr Perron, Private Citizen, JSCEOLC Transcript, 13 April 2018, Session 2 at 1.

358 Syme R (2008) *A good death: An argument for voluntary euthanasia*, Carlton, Victoria: Melbourne University Publishing at 30.

359 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 41.

360 See Dr Best, Palliative Care Physician and Academic, JSCEOLC Transcript, 1 May 2018, Session 2 at 5 and Prof Somerville, Professor of Bioethics, University of Notre Dame Sydney, JSCEOLC Transcript, 1 May 2018, Session 8 at 3.

361 Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 18 May 2018, Session 1 at 7.

362 Mr John McGrath, Committee member, JSCEOLC Transcript, 18 May 2018, Session 1 at 23.

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- 2.179. Assisted suicide is outsourced to private organisations in the Netherlands and Switzerland. However, such transparency would prove too great a hurdle for proponents of the legalisation of assisted suicide:

*It could all be managed privately, as it is being done already—to a large degree—in the Netherlands, Switzerland and the United States by the death lobby. But, if in the initial stages such an arrangement would have been advocated, it would have given rise to invincible resistance to the euthanasia movement. No, in its propaganda this movement needs to take advantage of the positive reputation of the medical profession and the idea of it being healthcare.<sup>363</sup>*

- 2.180. Boudreau and Somerville also identify the advantage proponents derive from aligning assisted suicide with the medical profession:

*The pro-euthanasia lobby derives advantages by aligning itself tightly with medicine and physicians. The history of physician involvement in capital punishment is illustrative of this strategy. Juries in the USA, who had seen horrific footage of convicted murderers being executed in the ‘electric chair,’ became reluctant to convict persons accused of capital offences or to vote for a death sentence for felons convicted of a capital offence. Most physicians and the American Medical Association adamantly opposed medicine’s involvement in administering capital punishment by lethal injections. Nevertheless, some physicians participated. By virtue of their involvement and in concocting a method of execution that makes a convicted criminal appear serene during final moments, enhanced acceptability was conferred on the procedure. It has been suggested that ‘the law turned to medicine to rescue the death penalty.’<sup>364</sup>*

### **The low number of doctors likely to participate in an assisted suicide program**

- 2.181. AMA(WA) recommend that consideration should be given to the number of doctors who would realistically be involved in assisted suicide, were it to be introduced. In a survey of its members conducted in 2016, 62 per cent said they would not provide physician-assisted suicide, while 25 per cent believed that they would. However the AMA note that in practice, this second figure is even lower. They refer to statistics in Canada which indicate that approximately 1 per cent of doctors have taken up the practice of assisting suicide. The AMA suggest that ‘[t]his has major implications for access to doctors

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363 Stahle F (2017) ‘Moral disengagement – Mechanisms Propelling the Euthanasia/PAS Movement,’ *Journal of Ethics in Mental Health* 10 at 13.

364 Boudreau and Somerville (2013) ‘Euthanasia is not medical treatment,’ *British Medical Bulletin* 106, 45-66 at 49-50.



providing assisted dying, potentially increasing disparity of treatment for those in lower resourced settings.<sup>365</sup>

- 2.182. It is also reported that in Oregon and Washington state very few physicians participate in physician-assisted suicide. Data on the practice of physician-assisted suicide in Oregon in 2015 reveals that the 218 prescriptions written under the legalised program in that State were written by 106 physicians, representing 1 per cent of actively licensed physicians.<sup>366</sup>
- 2.183. In relation to psychiatric assessment of patients requesting assisted suicide, research shows that while some 64 per cent of British psychiatrists agreed that psychiatric assessments are important in the physician-assisted suicide context, only 35 per cent would be willing to carry out such assessments. A pilot survey of RANZCP WA branch members indicated a similar trend.<sup>367</sup>
- 2.184. The major implications for access to doctors providing assisted dying, and the increasing disparity of treatment for those in lower resourced settings, is a very real issue and was the case in the Northern Territory when assisted suicide legislation was in operation there. This was identified by Dying With Dignity WA in their oral evidence to the Committee,<sup>368</sup> and in their submission where they state that:

*Western Australia, a truly vast State with a population highly centralised in a few locations, most especially Perth, has particular needs and difficulties that are not the same as those in Victoria, or even in NSW, and accordingly special consideration needs to be given to the needs of people living in remote and regional areas, many of whom are indigenous and suffer from various hardships, and in particular the law to be introduced needs to cater for the limited availability of specialist care to such persons.*

...

*Nor should there be a requirement that routinely one of the doctors must have specialist qualifications relating to the condition in question... there may be some cases where that would not be feasible or appropriate. It is to be remembered that in remote areas, access to specialists may be difficult and cause considerable delay; and that some*

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365 AMA(WA), JSCEOLC Submission 685 at 5.

366 Emanuel et al (2016) 'Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada and Europe,' *JAMA* 316(1), 79-90 at 83.

367 Royal Australian and New Zealand College of Psychiatrists (WA), JSCEOLC Submission 391 at 8.

368 Mr Walker, Vice President, Dying with Dignity WA, JSCEOLC Transcript, 13 April 2018, Session 5 at 5. See also the comments made by Mr Francis, Dying for Choice, JSCEOLC Transcript, 9 April 2018, Session 1 at 14.

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*doctors may choose not to assist, for personal ethical or religious reasons. Difficulties of these kinds beset the operation of the Northern Territory Act.*<sup>369</sup>

2.185. Their solution to address this disparity in healthcare resourcing for rural and remote areas is to expand the professions who may assist in a patient's suicide to include nurses as well as doctors, and to limit any requirement for medical specialist involvement. Dying with Dignity's concern that Indigenous Western Australians suffering from 'various hardships' will have limited access to assisted suicide services because of their remote location ignores the existing unaddressed problem of fear that some Indigenous people hold toward the medical profession.

2.186. The evidence of Dr Khorshid stands in direct contrast to the opinions held by Dying with Dignity WA:

*[The AMA] are still concerned that if the medical profession generally is associated with ending people's lives, that may create a further barrier to our Indigenous population accessing medical care. We know that some of their views around death are quite different to those of the western mindset. That is already a barrier to seeking medical care for certain Indigenous members of the community.*<sup>370</sup>

2.187. It is bad public health policy to prioritise ready access to a new 'end of life choice' like assisted suicide in the knowledge that access to existing choices like specialist palliative care is poor to variable for rural and remote Western Australians.

### **Finding 46**

Governing medical bodies both inside and outside Western Australia discourage medical practitioners from participating in assisted suicide, even if the local law allows it or decriminalises it.

### **Finding 47**

The licencing of medical practitioners to assist in the suicide of their patients alters the role of the medical profession.

### **Finding 48**

There are multiple conflicts of interest for a medical practitioner assisting in the suicide of their patient.

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369 Dying with Dignity (WA), JSCEOLC Submission 565 at 6 and 23-24.

370 Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 18 May 2018, Session 1 at 7.

**Finding 49**

An assisted suicide regime would improperly absolve a medical practitioner of responsibility for giving a lethal injection to their patient or for giving their patients a prescription to poison themselves.

**A Safeguard is Only as Good as the Doctor Enforcing it**

- 2.188. One of Australia’s most high profile proponents of assisted suicide, Mr Denton suggests that a major safeguard against abuse in the practice of assisted suicide is the conservatism of the medical profession:

*The second major safeguard is the conservatism of the medical profession—the professions’ ethic to help their patients to go as far with their lives as possible while respecting their autonomy, and their concern to protect the vulnerable, which includes suffering, dying people. This conservatism should not be under-estimated.*<sup>371</sup>

- 2.189. Mr Denton also placed emphasis on the trust we hold in the medical profession in evidence to the Committee, stating that ‘[w]e trust our medical profession and we trust them to make complicated judgements every day in our hospital system and in their offices.’<sup>372</sup>

- 2.190. Similar sentiments were repeated by Dr Syme in evidence to the Committee:

*I have helped a lot of people at the end of that life and it has always been my fundamental belief, or approach, to try to help people to go as far with their lives as possible. I believe that that will be the attitude of the majority of medical practitioners who become involved in assisted dying. Doctors are a conservative group; they will not want to be helping people with assistance to die without very, very due cause.*<sup>373</sup>

- 2.191. Magnusson also suggests that ‘careful screening is surely an essential precondition to rational euthanasia practice.’<sup>374</sup>

- 2.192. In his evidence to the Committee, however, Mr Denton confirmed that doctors would be less conservative now than they were at the time of the operation of the ROTI Act in the Northern Territory where, as noted above, there were very few medical practitioners willing to euthanise patients, or to even assess cases as the consulting doctor:

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371 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 41.

372 Mr Denton, Go Gentle Australia, JSCEOLC Transcript, 13 April 2018, Session 6 at 12.

373 Dr Syme, Medical Practitioner and Vice President of Dying with Dignity Victoria, JSCEOLC Transcript, 13 April 2018, Session 4 at 5.

374 Magnusson RS (2002) *Angels of death: exploring the euthanasia underground* at 213.

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*Mr DENTON: The Northern Territory cases took place, you may recall, in an extraordinarily heated atmosphere. It is very different from where we are now. Just to give you a sense, that was 1997. That was the first law written in the world. Four people died then under that law before it was repealed. These same kinds of laws are now available to over 100 million people around the world, so the whole thing has moved on a lot further since then. They happened in an atmosphere of extreme heat, where the AMA in the Northern Territory was warning doctors off against helping anybody because they would be liable for legal action. What happened under that law—and you will recall that federal politics came it into (sic.) very quickly; there was enormous media attention—I think was deeply distorted. I do not think doctors acted as they would now and I do not think patients were given the help that they would get now.*

*Hon NICK GOIRAN: So was the conservative culture of the medical profession that you referred to more conservative then in 1996 or is it more conservative now?*

*Mr DENTON: I cannot give a definitive answer to that, except to say that I think it is less conservative now, and I do not even say this critically...*

...

*Hon NICK GOIRAN: I am a little troubled that you say to the committee that the doctors are less conservative now than what they were 20 years ago if the conservative culture is to be the main safeguard.*

*Mr DENTON: No, you misunderstand me. You are taking the words “not conservative” as meaning reckless. Consultation with a patient, which is what I am advocating, is not being reckless. Consultation with a patient is being a good doctor.<sup>375</sup>*

- 2.193. That a doctor may be less conservative, or more likely to approve an assisted suicide request, than was the case in the Northern Territory in 1997 compromises the proposition that doctor conservatism is a ‘major safeguard,’ especially where the doctor may in fact be biased toward assisted suicide (considered further below).
- 2.194. What is also interesting is Mr Denton’s reliance on the conservatism of the medical profession to safeguard the assisted suicide process on the one hand, and his submission that ‘Doctors sign certificates every day where death was the result of sedation and

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375 Mr Denton, Go Gentle Australia, JSCEOLC Transcript, 13 April 2018, Session 6 at 8-9 (emphasis added).

withholding hydration. Who would know if the doctrine of double effect is shielding abuse or cover up?<sup>376</sup> Mr Denton appears to have very little faith in palliative care specialists in their current practice of end of life care, and yet he holds great faith in the medical profession to safeguard vulnerable patients under a legalised assisted suicide program where doctors are permitted to intentionally kill a patient.

- 2.195. A doctor would not have to be acting recklessly for abuse under assisted legislation to occur. Evidence has already been given in this Report that in jurisdictions with optional referral for psychiatric assessment, gatekeeping medical practitioners seldom refer and that this results in persons with treatable clinical depression being wrongfully assisted to commit suicide. Observers in the Netherlands have also concluded that the relevant legal guidelines in that jurisdiction are variously interpreted and definitions of ‘unbearable suffering’ differed considerably between doctors.<sup>377</sup> It has been noted that in relation to data from Washington State that error in accurate prognosis in assisted suicide cases has doubled, it is unlikely that medical practitioners have actually become less competent at prognosis. It is more likely that as assisted suicide becomes established, medical practitioners who participate in its operation by prescribing lethal doses of medication pay less attention to a statutory limit regarding expected time until death.<sup>378</sup>

- 2.196. Furthermore:

*Not all doctors are skilled in the management of patients with advanced cancer, are effective communicators, and have a thorough understanding of the relative benefits of pharmaceutical, neurosurgical and anaesthetic approaches to pain control. A particular concern is that some doctors (or health providers) do not realise the limitations of their knowledge. In some instances, they believe that if they cannot fix the problem it cannot be fixed! Whereas it is possible that the problem could be partially alleviated if the patient were to be referred to experts familiar with managing terminally ill patients.*

...

*For some doctors who are unaware of the other approaches, the next-best alternative is perceived as helping such patients to die. Their compassion and concern for the patient’s well-being inexorably lead to their acceptance of—and, ultimately for some, their practice of—euthanasia rather than resulting in true empathy and the insight to*

376 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 9.

377 Zalberg JR and Buchanan JD (1997) ‘Clinical issues in euthanasia,’ *MJA* 166 150 at 151, citing H Hendin (1994) ‘Seduced by death: doctors, patients and the Dutch cure,’ *Issues Law Med* 10, 123-168.

378 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 15-16, citing Washington State Department of Health, *Death With Dignity Act Reports*, 2009-2015.

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*involve expert professionals in helping to support patients and their families.*<sup>379</sup>

- 2.197. Mr Denton's high-stakes trust in the medical profession was challenged by Hon Nick Goiran MLC, who suggested that such an extreme level of trust may be misplaced:

*You have said a few times this afternoon or this evening for you that—you use the word “we”—we trust our doctors. I should perhaps disclose to you that before entering Parliament, I was a barrister and solicitor in Western Australia and part of my practice was medical negligence law, so I guess perhaps when you say “we,” as a society there are degrees of trust. Some of us are, perhaps through painful lived experience of our clients, a little less trusting than others.*<sup>380</sup>

- 2.198. Pollard and Winton's summation is succinct and to the point:

*We have not yet achieved excellence, or even satisfactory competence, in the limited tasks we have set ourselves in medical decision-making. There are still complaints about inattentive, uncommunicative doctors, inadequate pain control and neglectful care. Agreed patient rights are not always adequately observed. Where is the evidence that we would manage decisions any better when error would be tragic and irreversible?*<sup>381</sup>

### **Doctor bias toward assisted suicide**

- 2.199. Mr Denton suggests that the process of determining whether a patient can access assisted suicide is its own safeguard:

*What will happen is this: when a patient presents saying “I want help to die,” the doctor is going to ask, “why?” They're going to look at all that patient's symptoms. They're going to want to know what's going on in that patient's life that's making them feel like they no longer want to live.*<sup>382</sup>

- 2.200. Evidence of doctor bias toward assisted suicide indicates that such a process is no safeguard at all, or at best that such a safeguard is only as good as the doctor involved.

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379 Zalcberg JR and Buchanan JD (1997) 'Clinical issues in euthanasia' *MJA* 166 150 at 151.

380 Mr Denton, Go Gentle Australia, JSCEOLC Transcript, 13 April 2018, Session 6 at 12.

381 Pollard B and Winton R (1993) 'Why doctors and nurses must not kill patients,' *MJA* 158, 426-429 at 428.

382 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 40.

- 2.201. Dr Syme acknowledges that there is a possibility for bias to be held by the doctor in his statement that '[i]t is essential that one's innate sympathy for a person's suffering does not introduce bias into one's decisions.'<sup>383</sup>
- 2.202. In discussing the attitudes held by medical professionals toward euthanasia, Magnusson notes that '[a]t one extreme, some revisionists display what we call the 'Rambo' or 'cowboy' factor: an almost reckless individualism which most readers, we believe, would find disturbing.'<sup>384</sup> Magnusson further observes that:

*The overwhelming majority of those interviewees who were implicated in 'disturbing' episodes [of illegal euthanasia of a patient] were simultaneously gracious and dedicated professionals who inspired trust, and who genuinely cared about the suffering of their patients. It is difficult not to recall the interview with Richard, an opponent of euthanasia, who said: "I don't idealise doctors. They are fairly ordinary people with many of the same frailties which most people have, although hopefully accustomed to operating within a professional framework."<sup>385</sup>*

- 2.203. Professor Michael Quinlan, Dean of the School of Law Sydney at the University of Notre Dame Australia, notes that the legalisation of assisted suicide will most likely attract participation of medical practitioners who are also advocates of the practice:

*[I]f euthanasia were to be legalised, participation by medical practitioners (or others given authority by the State to euthanise) would be voluntary. This in itself may create issues of concern, as advocates for euthanasia may be most attracted to take up that role. Indeed, in the brief period of operation of the NT [ROTI] Act, the euthanasia campaigner Dr Nitschke administered euthanasia to all of those who accessed the procedure. Some such doctors may consciously or unconsciously have a preference for euthanasia. This may result in an actual or, at least, perceived conflict of interest particularly given the fiduciary relationship of trust that exists between a doctor and patient. Quite unlike a hangman or executioner administering a lethal injection, a doctor who administers euthanasia will have a clear doctor-patient fiduciary relationship. Such a doctor may well have been involved in assisting the patient to decide on the course of euthanasia and have facilitated the achievement of that objective. For example, during the brief operation of the NT [ROTI] Act, Dr Nitschke paid for the*

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383 Syme R (2008) *A good death: An argument for voluntary euthanasia* at 191.

384 Magnusson RS (2002) *Angels of death: exploring the euthanasia underground* at 105.

385 *Ibid* at 208.

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*fees of one of the psychiatrists who signed off on the availability of euthanasia for one of his patients.*<sup>386</sup>

- 2.204. Evidence to support this concern about doctor bias is also found in Oregon, where a physician member of a pro-assisted suicide lobby group provided the consultation in 58 of 61 consecutive cases of patients receiving physician-assisted suicide in Oregon.<sup>387</sup> This evidence raises concerns about the objectivity of the process and the safety of patients, and the influence of bias on the decision-making of these physicians in the assisted suicide process.<sup>388</sup>

### **Doctor shopping**

- 2.205. Concern about doctor shopping was expressed to the Committee by the AMA(WA):

*In terms of the decision to proceed and an approval process, we are not comfortable with two independent doctors agreeing with each other. We find that to be fundamentally flawed. If an individual wanting to seek euthanasia did not meet the criteria by two particular doctors, they will go and find another two doctors that do agree with them. We know this occurs right now in medicine in Western Australia where if doctors do not give you the answer that you want, you just go find another one. Doctors are good at certain things in medicine, we are okay at other things, but we are not skilled in all of these sorts of decisions.*<sup>389</sup>

- 2.206. The probability of doctor shopping occurring under a legalised assisted suicide scheme was also addressed by Rev Saunders, an accredited personal injury lawyer specialist, in this exchange with Hon Nick Goiran MLC:

*Hon NICK GOIRAN: Would it be common for you in your experience as an accredited personal injury lawyer specialist to have to seek out those medical opinions from time to time?*

*Rev. SAUNDERS: Yes, in every case.*

*Hon NICK GOIRAN: If one of the safeguards was to have more than one medical practitioner to provide a diagnosis, how difficult would it be to get two doctors to agree?*

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386 Quinlan M (2016) “Such is Life”: Euthanasia and capital punishment in Australia: consistency or contradiction?’ *Solidarity: The Journal of Catholic Social Thought and Secular Ethics* 6(1) at 21-22.

387 Hendin and Foley (2008) ‘Physician-assisted suicide in Oregon: a medical perspective,’ *Mich Law Rev* 106, 1613–40.

388 Pereira J (2011) ‘Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls,’ *Current Oncology* 18(2) 38-45 at 40.

389 Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, Session 1, 18 May 2018 at 6.



*Rev. SAUNDERS: Can I say with the greatest of respect to medicolegal practitioners, it would not be very difficult at all. Does it come as a surprise to members of this committee to hear that in every case where you act for a plaintiff you present two or three medical reports that are very favourable to the plaintiff while at the same time in the very same case the defendant will present two or three medical reports that will say something entirely different? That is the reality of medicolegal practise in Australia.*

*Hon NICK GOIRAN: So you just keep shopping until you get the opinion you want?*

*Rev. SAUNDERS: I would like to think that we did not, but is that, in terms of the areas of interest of this committee, a realistic danger? In my view, yes.<sup>390</sup>*

2.207. Magnusson also raises the issue of doctor shopping:

*Nevertheless, since a treating physician may not wish to perform euthanasia, it is inevitable that terminally ill patients may end up 'shopping' for a doctor prepared to assist them. Quill and colleagues emphasise that 'physician-assisted suicide should be carried out only in the context of a meaningful doctor-patient relationship. Ideally, the physician should have witnessed the patient's previous illness and suffering.' Miles fears that legalisation may 'empower not only physicians with good relationships, but also those with transient, inadequate, or troubled relationships with chronically ill patients.'<sup>391</sup>*

2.208. How a legislative scheme for assisted suicide could ensure that assisted suicide was only carried out in the context of a meaningful doctor-patient relationship is not self-evident.

#### **Finding 50**

A safeguard in an assisted suicide regime that involves a medical practitioner is only as safe as the practitioner is competent.

#### **Finding 51**

A safeguard in an assisted suicide regime that involves a medical practitioner is unable to protect against unconscious incompetence.

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390 Rev Saunders, National Director, FamilyVoice Australia, JSCEOLC Transcript, 9 March 2018, Session 3 at 7.

391 Magnusson RS (2002) *Angels of death: exploring the euthanasia underground* at 278-9.

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### Finding 52

A safeguard in an assisted suicide regime that involves a medical practitioner is unable to protect against mistake, error or negligence.

### Finding 53

Legalisation of assisted suicide will attract participation by medical practitioners who are also advocates of the practice.

### Finding 54

Even if the risk of doctor bias toward assisted suicide is the same as doctor bias in general, the consequences are not comparable.

### Finding 55

Doctor shopping is a clear danger of an assisted suicide regime, with no solution apparent.

## Medical Error in Diagnosis and Prognosis

2.209. Mr Denton suggests that:

*Doctors who object [to ‘voluntary assisted dying’ or assisted suicide] portray it as though they are being asked to ‘kill’ a patient. In reality, what they’re being asked to do is what they already do—make a careful diagnosis that a patient’s condition is terminal, and at its end stages, and their suffering is intolerable, and go through with them their treatment options.*<sup>392</sup>

2.210. The requirement for ‘a careful diagnosis that a patient’s condition is terminal and at its end stages’ is no meaningful safeguard when the large body of evidence of medical error in prognosis, and even in diagnosis, are considered.

### Error in prognosis

2.211. Much evidence was received by the Committee as to the risk of medical error in prognosis. In relation to the unworkability of a safeguard that requires a time period before death, as is incorporated into the Victorian legislation, Dr Nitschke said:

*What period defines a person’s terminal status—is it six months, is it nine months? Oh, well, we have decided to make it even safer by making it six months. Most doctors involved watching that process closely just shrugged at that point, because that is an almost impossible decision to*

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392 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 43 (emphasis added).

*make. You just have no idea whether a person is going to live for six months or nine months.*<sup>393</sup>

- 2.212. The AMA(WA) highlighted the complexity involved in medical decision making:

*Really the point is that everything is far more complex in reality than it sounds when you are writing down rules on a piece of paper. A key example, one that has stuck in my mind, was her example of the most wrong she has got prognosis as a palliative care physician where an individual she talked about was given a few weeks or months to live and is still going strong decades later. We do get prognoses wrong and we need to understand that everything we talk about is grey when we are talking about end-of-life issues.*<sup>394</sup>

- 2.213. Committee member Mr John McGrath also noted:

*I just want to make a quick comment. I think that is the crux of the whole thing. Obviously, the best doctor in the world does not know when someone is going to die precisely. I know people who have been sent home and they have been told that they have six months to live, and four years later you still seeing them walking around. It is an impossibility for the medical profession to make decisions that can be so accurate.*<sup>395</sup>

- 2.214. Mr Wayne Belcher OAM, Chief Executive Officer of Braemar Presbyterian Care, also noted:

*[W]e have a resident in one of our facilities now who was told by his GP that his prognosis was to die before Christmas 2016. He is still with us. Medicine is not an exact science.*

...

*The difficulty for medicine is that it is not an exact science. It is good, and even the advances made in the last 30 or 40 years—I would not want to be around 40 years ago, given the things that are happening today. Some of those advances are great, but prognosticating about the time when the terminal phase of life is upon us—it is not there; it is not a pure science.*<sup>396</sup>

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393 Dr Nitschke, Exit International, JSCEOLC Transcript, 13 April 2018, Session 1 at 12.

394 Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 18 May 2018, Session 1 at 6.

395 Mr McGrath, Committee Member, JSCEOLC Transcript, 13 December 2017, Session 2 at 21.

396 Mr Belcher, CEO Braemar Presbyterian Care, JSCEOLC Transcript, 27 February 2018, Session 2 at 7 and 12.

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- 2.215. Professor Douglas Bridge, Senior Palliative Care Specialist, shared his personal experience in prognostic error:

*I did a survey of my own results. I thought, "How good am I at guessing?", so I checked. Forty times I used this thing. One patient had been discharged. I rang up the nursing home and said, "Can you please tell me what day this person died?" They said, "He's still alive," six months later. So 39 of the 40 died in two or three days; one, I felt very embarrassed. I thought he was on the point of death and he woke up and got better, so we cannot always predict death.<sup>397</sup>*

- 2.216. Western Australia's Chief Psychiatrist, Dr Gibson, stated:

*It is tricky, because it is also about prognosis. We know that prognosis is flawed. A cancer specialist might say that you have six months and you might last two years. It is the same with things like dementias. A specialist might say you have two to five years to live with this dementia, and someone might live for 10 years. So, there is also that issue of prognosis, I think, which lawmakers have to consider as part of the process.<sup>398</sup>*

- 2.217. In contrast to this evidence, Mr Denton gave the following evidence to the Committee:

*I guess the other interesting thing to say is that research shows that there is no perfect science to diagnosis and doctors, by some considerable margin, are over-optimistic in their diagnosis of terminal patients. They give them longer to live than they actually turn out to live. There is a great deal of evidence to support that. If you are talking about doctors making errors in an imperfect science, then, unfortunately, they err on the side that is not most useful to the patient.<sup>399</sup>*

- 2.218. This suggestion from Mr Denton completely contradicts the substantial evidence available that doctors frequently under-estimate the prognosis of their patients, including evidence from jurisdictions where assisted suicide has been legalised. Mr Egan of Defend Human Life! has analysed the reporting data from Oregon and Washington which shows the frequency with which patients accessing assisted suicide in those

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397 Prof Bridge, Senior PC Specialist, UWA Faculty of Medicine and Health Sciences; WA Country Health Service, Royal Perth Hospital, JSCEOLC Transcript, 9 March 2018, Session 5 at 12.

398 Dr Gibson, Chief Psychiatrist of Western Australia, JSCEOLC Transcript, 28 February 2018, Session 3 at 11.

399 Mr Denton, Go Gentle Australia, JSCEOLC Transcript, 13 April 2018, Session 6 at 13.

jurisdictions have lived longer than the prognosis given by the consulting doctor, the prognosis of which deemed them eligible to access lethal medications:

*[T]he longest duration between initial request and ingestion recorded is 1009 days (that is 2 years and 9 months). And in the most recent year for which data is available, that is 2015, one person ingested lethal medication 517 days after the initial request for the lethal prescription was made.<sup>400</sup>*

2.219. Data from the Oregon *Death With Dignity Act* annual reports shows that:

- in every year of full operation of the Act (1999-2015) there is at least one case (almost certainly many more but only the longest duration is reported in the data) where the time between initial request and ingestion was greater than nine months;
- in 14 of the 17 years there was at least one case where the time between initial request and ingestion was greater than one year;
- in 10 of the 17 years there was at least one case where the time between initial request and ingestion was greater than 15 months;
- in 6 of the of the 17 years there was at least one case where the time between initial request and ingestion was greater than 18 months, and
- in 4 of the 17 years there was at least one case where the time between initial request and ingestion was greater than two years.

2.220. Evidently in each of these cases the prognosis of less than six months to live was wildly inaccurate.<sup>401</sup>

2.221. Although Washington state's *Death With Dignity Act* specifies that only persons with 'six months or less to live' may request lethal doses of medication from a physician, the data shows that in each year between 5 and 17 per cent of those who die after requesting a lethal dose do so 25 weeks or more later, with one person in 2012 dying nearly 3 years (150 weeks) later, and one person in 2015 dying nearly two years later (95 weeks). Washington physicians who prescribe lethal medication seem to be getting more inaccurate in their prognoses for assisted suicide candidates. In the first three years of

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400 Oregon Public Health Division (2016) 'Oregon's Death With Dignity Act: 2015 Data Summary, Table 1. Characteristics and end-of-life care of 991 DWDA patients who have died from ingesting DWDA medications, by year,' Oregon, 1998-2015 at 7, cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 14.

401 Data obtained for each year of operation of the *Death With Dignity Act* from the Oregon Health Authority, *Death With Dignity Annual Reports* by Mr Egan, Research Officer, Defend Human Life, JSCEOLC Submission 5 at 14-15.

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the Act's operation (2009-2011) 6.43 per cent of persons who died after ingesting a prescribed lethal dose 25 weeks or more after the initial request. However, this rate of inaccurate prognosis more than doubled to 13.33 per cent over the next four years of the Act's operation (2012-2015).<sup>402</sup>

- 2.222. Mr Egan also cites many peer-reviewed studies of prognostic accuracy demonstrate the statement made by Mr Denton to be incorrect:

*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.'<sup>403</sup>*

*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 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.'<sup>404</sup>*

*A study on the accuracy of prognoses in oncology found that 'discrimination between patients who would survive for one year and*

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402 Washington State Department of Health, *Death With Dignity Act Reports, 2009-2015*, cited in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 15-16.

403 Kondziolka D (2014) 'The accuracy of predicting survival in individual patients with cancer,' *Journal of Neurosurgery*, 120(1), 24-30, cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 16.

404 Christakis NA (2000) 'Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study,' *BMJ* 320, 469 cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 16.

*those who would not was very poor,<sup>405</sup> and can be described as ‘only slightly better than a random guess.’<sup>406</sup>*

- 2.223. The Australian Commission on Safety and Quality in Health Care state in their National Consensus Statement that:

*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.<sup>407</sup>*

- 2.224. Mr Egan suggests that the critical point to note here 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. However, using a 12 months to live criteria to prescribe or administer lethal drugs (perhaps as soon as 10 days after such a prognosis is first given) excludes these possibilities.<sup>408</sup>

- 2.225. Golden and Zoanni also state that it is extremely common for medical prognoses of a short life expectancy to be wrong, citing studies that show that only cancer patients show a predictable decline, and even then that this decline is only in the last few weeks of life. These studies show that with every disease other than cancer, prediction is unreliable.<sup>409</sup> They write:

*Prognoses are based on statistical averages, which are nearly useless in determining what will happen to an individual patient. Thus, the potential reach of assisted suicide is extremely broad and could include many people who may be mistakenly diagnosed as terminal but who have many meaningful years of life ahead. This poses considerable danger to people with new or progressive disabilities or diseases, who*

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405 Mackillop and Quirt (1997) ‘Measuring the accuracy of prognostic judgments in oncology,’ *Journal of Clinical Epidemiology* 50(1) 21-9, cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 17-18.

406 White et al (2016) ‘A systematic review of predictions of survival in palliative care: How accurate are clinicians and who are the experts?’ *PLOS One*, cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 17-18.

407 Australian Commission on Safety and Quality in Health Care (2015) *National Consensus Statement: essential elements for safe and high-quality end-of-life care* at 17.

408 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 18.

409 Golden and Zoanni (2010) ‘Killing Us Softly: The Dangers of Legalizing Assisted Suicide,’ *Disability and Health Journal* 3(1) 16-30 at 21.

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*may often be misdiagnosed as terminally ill but who, in many cases, outlive these prognoses by years or even decades.*<sup>410</sup>

- 2.226. Magnusson, in citing the confronting tactic of euthanasia campaigners to use dying patients for propaganda purposes, refers to a case from New South Wales:

*Perhaps the most confronting tactic of euthanasia campaigners is to use dying patients themselves. In 1999 the New South Wales Voluntary Euthanasia Society produced a shock television commercial featuring June Burns, a dying cancer patient and mother of four, who told viewers 'I feel life is very precious and I've enjoyed every moment of it and I wish I could go on but I can't and I'd like to die with dignity.' Eight months later June was reported to be in remission, her doctors believing she could live for another two years.*<sup>411</sup>

### **Error in diagnosis**

- 2.227. Evidence was also presented to the Committee on the prevalence of misdiagnosis by medical practitioners. Dr Khorshid informed the Committee that:

*Sometimes you will have a doctor who will say, "You've got a day to live; sort out your affairs," and the patient is still going a year later. We make mistakes, and that is one of the complexities in this area. Somebody thinks they have got a certain period of time but that could be completely wrong—the diagnosis can be wrong, the prognosis can be wrong and strange things happen. That is the reality of dealing with people.*<sup>412</sup>

- 2.228. Avant Mutual, a large medical indemnity insurer, presented evidence to the Committee that in the 2017 financial year, of 16 closed matters in Western Australia where diagnostic error was the primary allegation, approximately one third of those diagnostic error cases were not resolved in the doctor's favour.<sup>413</sup> In reviewing their national claims data for 2017, there were 33 matters relating to end of life care and around half of those matters related to diagnostic error.<sup>414</sup>

- 2.229. Avant Mutual research referred to the Committee also shows that:

*Accurate diagnosis is key to understanding a patient's health concern and making appropriate care decisions. However, diagnosis is estimated to be incorrect roughly 10% of the time. Although true incidence data*

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410 Ibid.

411 Magnusson RS (2002) *Angels of death: exploring the euthanasia underground* at 268.

412 Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 28 February 2018, Session 2 at 9.

413 Avant Mutual, JSCEOLC Response to Questions on Notice, 26 March 2018 at 1.

414 Ibid.



are lacking, mounting evidence suggests diagnostic errors result in an alarming rate of patient harm and death.<sup>415</sup>

Diagnostic errors are common, appear in every healthcare setting and occur when diagnosing common and unusual conditions. While it is important to acknowledge that some diagnostic errors result from factors outside of a doctor's control, or are simply unavoidable (e.g. an undetectable malignancy, a typical presentation of a disease, incorrect information from a patient), the majority involve a doctor making a cognitive error, usually several types.<sup>416</sup>

Our analysis also highlighted the seriousness of injuries seen in diagnostic error claims. In almost half (46%) of all matters where a doctor's actions allegedly resulted in serious permanent physical injury or death, diagnostic error was alleged to be the cause. This rate was higher than all other types of allegation. For general practitioners, the rate was particularly high.<sup>417</sup>

2.230. Avant Mutual also cite Dr Walid Jammal, who states:

*Making a correct diagnosis remains to me, as a doctor, a quintessential sign of my clinical competency. Yet despite all the technological advances that surround us all, making a correct diagnosis remains a challenging task. I am constantly aware of the possibility of making a diagnostic error. The more experienced I become, the more I realise that there are no shortcuts. Every step of the iterative process involved in reaching a correct diagnosis requires my constant attention. I am constantly learning and adapting. I am learning to listen better to patients. In a complex medical world, I am realising that I am no longer what I was taught to be: a "lone ranger." I am constantly trying to instil team work, trust, and collaboration into the way I work. Examining and understanding the way I think, my cognitive processes, and what factors influence my reasoning, have helped me improve. But most importantly,*

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415 'Avant research reveals factors underlying diagnostic error claims,' 12 March 2018, Avant article referred to in JSCEOLC Response to Questions on Notice, 26 March 2018 (emphasis added), citing Clinical Excellence Commission (2015) *Diagnostic Error: Learning Resource for Clinicians*, and Graber ML (2013) 'The incidence of diagnostic error in medicine' *BMJ Qual Saf* 22:ii21–ii27.

416 'Avant research reveals factors underlying diagnostic error claims,' 12 March 2018, Avant article referred to in JSCEOLC Response to Questions on Notice, 26 March 2018 (emphasis added), citing Clinical Excellence Commission (2015) *Diagnostic Error: Learning Resource for Clinicians*; National Academies of Sciences, Engineering, and Medicine, Institute of Medicine (2015) *Improving Diagnosis in Health Care*, Washington, DC; and Jammal and Lewis (2017) 'Cognitive bias and failure to diagnose: when you need to "think slow,"' *Medicine Today* 18(9), 65-67.

417 'Avant research reveals factors underlying diagnostic error claims,' 12 March 2018, Avant article referred to in JSCEOLC Response to Questions on Notice, 26 March 2018 (emphasis added).

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*errors I have made have taught me to make the patient the most important part of the team. I have learnt that constantly adapting, communicating, managing expectations, and maintaining a good relationship with the patient are the most crucial part of helping me avoid errors and their associated complaints and claims.*<sup>418</sup>

2.231. Mr Peter McClennan, Chief Executive Officer of medical insurance company Best Doctors, suggests that 10 per cent of patient cases in Australia are mis-diagnosed.<sup>419</sup>

2.232. The possibility of difference in medical opinion on diagnosis was also identified by Rev Saunders, who confirmed from his experience in his practise of medical negligence and personal injury law that difference in diagnosis would frequently occur:

*Of course, in every case. In every case that went to court you would have competing medical evidence; you would have one doctor saying this and another doctor that. Sometimes it was a difference of interpretation; other times it was even a difference of causation, a difference of diagnosis. So, yes, those differences went from what I might call the “nuanced” differences right through to diametrically opposed diagnoses.*<sup>420</sup>

2.233. In evidence given to the Committee regarding the end of life care of his wife, who suffered from progressive sub-cranial palsy, and whose request that antibiotics not be administered was not followed by the care facility in which she lived, Mr Bruce Buchanan gave evidence of his own experience of the misdiagnosis of a terminal condition:

*I was diagnosed with cancer of the pancreas and I was given five weeks to live. At the point where this came up, I collapsed. The initial signs of cancer of the pancreas are jaundice, blockage of the bile duct and pain. I had jaundice and a blockage of the bile duct, but I did not have any pain. It is common, as it were. I am not a medical person, but from what I know of it, if you have got those symptoms, you have got either kidney stones, cancer of the pancreas or, in one in umpteen many chances, something else, and that is what I had—the something else. In fact, in hospital they said, “Sorry, chum; you’ll be dead in about five weeks. We’re going to send you up to Fiona Stanley to see what we can do for you, but this is it.” I had the slightly unpleasant task of ringing my wife,*

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418 Dr Walid Jammal, Senior Medical Advisor, Advocacy, Avant Mutual, quoted in ‘Avant research reveals factors underlying diagnostic error claims,’ 12 March 2018, Avant article referred to in JSCEOLC Response to Questions on Notice, 26 March 2018.

419 Alice Uribe, ‘Doctors Mis-Diagnose 1 in 10, says insurer,’ *Australian Financial Review*, 28 August 2017, cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 17.

420 Rev Saunders, National Director, FamilyVoice Australia, JSCEOLC Transcript, 9 March 2018, Session 3 at 7.

*who was in an aged-care facility because I could not look after her, to say, "Sorry; I won't see you again. I'll be dead before anything happens." Fortunately, when I got to Fiona Stanley, what they firstly do is they unblock your bile duct and you start to get better, and then the cancer of the pancreas should knock you off. The doctor was simply incompetent, and I say that advisedly. We all make mistakes—maybe parliamentarians do not make mistakes! But everybody else does in the world. It was more than that; it was simply incompetence, because he could have easily discovered whether or not I had cancer by a simple needle biopsy of my pancreas, which took about an hour or less, because I had one much later on when I had not died and they said, "We think you've got something else." They said, "We'd better check up to see that your pancreas is all right" and an hour later someone trots in and says, "There's no cancer at all." I had spent all this time expecting to die and telling everyone else that I had cancer and I had not. It was an interesting experience, I can tell you.<sup>421</sup>*

- 2.234. Mr Buchanan was diagnosed with pancreatic cancer and spent five months in palliative care before his misdiagnosis was identified after he outlived his prognosis by many months. Mr Buchanan was actually suffering from a chronic inflammatory condition called immunoglobulin 'IgG4' disease which affected his pancreas. His misdiagnosis of advanced terminal pancreatic cancer would have caused Mr Buchanan and his wife extreme distress, and stands as a terrible record of medical practitioner error. However more than that, it is evidence of the risk that Western Australians would be exposed to under any legalised assisted suicide regime, for Mr Buchanan's misdiagnosis would have made him eligible to access assisted suicide.
- 2.235. That patients may be assisted to suicide on the basis of misdiagnosis is not a purely theoretical assertion. Evidence is also available that misdiagnosis *has* occurred in patients who have been euthanised:

*Using Nembutal, the drug Nitschke says he "promotes," 70-year-old Gold Coast widow Nancy Crick killed herself in May 2002. Nitschke had been her doctor, publicised her case, told her how to kill herself and helped arrange for her to die surrounded by 21 euthanasia activists. An autopsy later revealed Crick had no trace left of cancer—a fact of which her son said she was not aware.<sup>422</sup> Nitschke said whether or not she had cancer was "irrelevant."<sup>423</sup>*

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421 Mr Buchanan, Private Citizen, JSCEOLC Transcript, 1 May 2018, Session 9 at 7.

422 A Bolt, 'At last, we wake up to Dr Death, Philip Nitschke' *Herald Sun*, 6 July 2014.

423 'The troubling death of Nancy Crick' *The Age*, 28 May 2002.

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And:

*[I]t 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.<sup>424</sup>*

2.236. Mr Egan concludes that:

*Published research on the accuracy of prognoses and diagnoses, as well as data from jurisdictions with a 6 months to live criterion, all point to the reality that under assisted suicide laws some people will die who are not terminally ill (errors in diagnosis), could be cured (wrong advice or reluctant to undergo treatment for reasons that could be overcome with the right help) or having much longer to live than predicted (errors in prognosis).<sup>425</sup>*

### **Finding 56**

There is a large body of evidence of medical error in prognosis.

### **Finding 57**

Any safeguard in an assisted suicide regime is rendered useless in the event of medical error in prognosis.

### **Finding 58**

There is a large body of evidence of medical error in diagnosis.

### **Finding 59**

Any safeguard in an assisted suicide regime is rendered useless in the event of medical error in diagnosis.

## **There is No Right to Receive Assistance from a Physician to Suicide**

2.237. Professors Willmott and White suggest that the since an individual has the right to self-determination, it follows that the individual also has the right to receive assistance to die:

*The right of a competent person to make decisions that affect her or his own life is seen as fundamental in a liberal democracy such as Australia... This right of self determination should entitle a competent*

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424 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 17, citing 'Aided suicide in question after botched diagnosis,' *The Local*, 11 July 2013.

425 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 14.

*person who is informed of her or his medical diagnosis, prognosis, treatment options and consequences of those options to choose the manner in which he or she dies. This right includes the right to ask for someone else to end her or his life, or to receive assistance to die.*<sup>426</sup>

- 2.238. The flaw in this view is immediately apparent and was raised by Ms Re of IdentityWA in her evidence to the Committee:

*In keeping with the social theory of individualism, [Professors Willmott and White] extend the definition of autonomy to self-determination which they hold involves having a person's will respected and acted upon. In other words, a person determines that what they want is suicide, and therefore they shall have it. Our position sees no conflict in "respecting" a person's will to suicide in the sense that this will is acknowledged. That is a basic premise of accompaniment. However, [the Professors] erroneously equate the expression of autonomy (or self-determination) with its fulfilment, as in a person's will is to be "acted upon."*

...

*[Professors Willmott and White at page 492 of Chapter 26] fail to consistently apply the principle of autonomy in the pursuit of fulfilling the will. If a person wills to commit suicide, then consistently applied autonomy dictates this is accomplished by the individual. Demanding intervention to fulfil an individual's will to suicide automatically involves a completely separate individual (such as a doctor), and the principle of autonomy no longer applies. This is precisely the issue that Parliament is confronting: on what basis might some instances of the currently legislated homicide be permitted, but not other instances? This explains why suicides are investigated as suspicious deaths.*<sup>427</sup>

- 2.239. By law, patients in Western Australia have the negative right to refuse nutrition and hydration, and indeed medical treatment, based on the right to inviolability. These rights were confirmed in the judgment of Martin CJ in *Brightwater Care Group (Inc) v Rossiter*.<sup>428</sup> In that judgment, the Chief Justice noted that in his Second Reading speech in support of the *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA), which

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426 White and Willmott (2012) 'How should Australia regulate voluntary euthanasia and assisted suicide?' *Journal of Law and Medicine* 20, 410-438 at 418, provided in Prof Willmott and Prof White, Directors, Australian Centre for Health Law Research, and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, JSCEOLC Submission 560.

427 Ms Re, Chief Executive Officer, IdentityWA, JSCEOLC Response to Questions on Notice, 10 April 2018 at 1-2.

428 [2009] WASC 229.

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created Advance Health Directives and Enduring Powers of Guardianship in Western Australia, the then Attorney General, Hon Jim McGinty MLA clarified that although a patient, or someone on the patient's behalf, will be entitled to refuse lawful treatment, there will still be no legal entitlement by a patient to demand treatment.<sup>429</sup>

- 2.240. It follows that the medical profession operate within the bounds of ethical responsibilities, and are not merely providers of a service on demand:

*Only by this balancing of ethical principles can physicians fulfil their duties, including those in more everyday encounters, such as when a physician advises against tests requested by a patient that are not medically indicated, declines to write an illegal prescription, or breaches confidentiality to protect public health. It also undergirds the physician's duty not to engage in futile care (such as care based on requests for non-indicated cardiopulmonary resuscitation or end-of-life treatment of brain-dead patients under an expansive view of patient autonomy). Physicians are members of a profession with ethical responsibilities; they are moral agents, not merely providers of services.*<sup>430</sup>

- 2.241. The suggestion that there is a patient right to receive assistance to die is entirely false and unfounded in law and medical ethics.

### **Finding 60**

Although a patient, or their substitute decision maker, is entitled to refuse lawful treatment, there is no entitlement at law by a patient to demand treatment.

### **Finding 61**

The proposition that a patient has a right to received assistance to suicide is wrong both at law and in medical ethics.

## **What Effect does Killing Patients have on Medical Professionals?**

- 2.242. Finally, the effect of killing a patient on the wellbeing of the medical practitioner must be considered.
- 2.243. Accounts from practitioners who have engaged in the intentional killing of a patient clearly reveal the toll that action takes on the practitioner:

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429 *Brightwater Care Group v Rossiter* [2009] WASC 229, per Martin CJ, para 47 at 16 (emphasis added).

430 Snyder, Sulmasy and Mueller (2017) 'Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper,' Professionalism and Human Rights Committee of the American College of Physicians, *Annals of Int Med* 167(8) 576 at 577.

*Harvey, an unassuming general practitioner, admitted to performing euthanasia 'probably a dozen times' over a number of years. He explains that 'on an ethical level...I support people's right to choose...to end their own life.' As an individual, however, he said, 'I find it very stressful dealing with it'. Harvey believes that 'having assisted people before...there is only a finite [number] of times that you can do it', because it is 'very draining' and 'ugly.'*<sup>431</sup>

*'I get sad', said Gary, 'I get depressed; it's not nice to kill someone, it's not an easy thing to do [although] it does get easier with time—after doing several, that's easier than the first couple.'*<sup>432</sup>

*'You can never get over the feeling of being executioner—you're turning up at an appointed time; you know that when you leave the room, the person is going to be dead'—Dr Philip Nitschke*<sup>433</sup>

- 2.244. Dr Best gave evidence to the Committee that Belgian health professionals have reported a great degree of moral distress in having to be involved in the practice of assisted suicide and that to be both practising palliative care and administering euthanasia was extremely difficult with a high psychological cost for that group of doctors.<sup>434</sup>
- 2.245. A 2011 survey among Dutch physicians found that 86 per cent of physicians dread the emotional burden of performing euthanasia.<sup>435</sup> Interviews of physicians who have participated in euthanasia (where the doctor provides a lethal injection) and physician-assisted suicide (where the doctor provides a lethal medication to a patient who self-administers that drug) indicate that the decision to go through with a procedure is neither easy nor straightforward.<sup>436</sup>
- 2.246. Studies confirm that doctors pay a high psychological price for their involvement in assisted suicide. Stahle notes the work of Dr Kenneth Stevens, from Oregon, who has compiled physicians' experiences from many different sources. Stevens concludes 'that

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431 Magnusson RS (2002) *Angels of death: exploring the euthanasia underground* at 106.

432 Ibid at 10.

433 Philip Nitschke quoted in C Henderson, C Ryan and T Aubin, 'A Fight to the Death' *Who*, 23 February 1998 at 35, and cited in Magnusson RS (2002) *Angels of death: exploring the euthanasia underground* at 174.

434 Dr Best, Palliative Care Physician and Academic, JSCEOLC Transcript, 1 May 2018, Session 2 at 5.

435 Van der Heide and Onwuteaka-Philipsen et al (2012) *Second Evaluation of the Euthanasia Law*, cited in Emanuel et al (2016) 'Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada and Europe,' *JAMA* 316(1) 79-90 at 87.

436 Emanuel et al (2016) 'Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada and Europe,' *JAMA* 316(1) 79-90 at 87, citing Dobscha, Heintz, Press and Ganzini (2004) 'Oregon physicians' responses to requests for assisted suicide: a qualitative study,' *J Palliat Med* 7(3) 451-461 and Ganzini et al (2001) 'Oregon physicians' attitudes about and experiences with end-of-life care since passage of the Oregon Death with Dignity Act,' *JAMA* 285(18) 2363-2369.

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the emotional and psychological effects on the participating physician can be substantial ... [and] can have significant effects on many participating physicians.’ As one of many examples, he refers to a television program reporting a euthanasia case, in which the Dutch physician who performed euthanasia noted that:

*To kill someone is something far reaching and that is something that nags at your conscience... I wonder what it would be like not to have these cases in my practice. Perhaps I would be a much more cheerful person.*<sup>437</sup>

2.247. Stahle also notes the comments of Jonquiere, a euthanasia practitioner from the Netherlands, who admits that helping someone to end their life places a heavy burden on the provider of such services. In light of this burden, Jonquiere’s recommendation is that doctors begin with the most obvious cases of suffering. ‘I always refrain from using the term “killing.” You terminate life—and actually, more than that, you terminate the suffering,’ Jonquiere says. ‘Get used to that idea, because it is counter-human a little bit. It never will be a routine action.’<sup>438</sup>

2.248. The desensitisation of the medical practitioner involved should be of significant concern. The effect of repeated involvement in the intentional killing of a patient is referred to in the Magnusson account of ‘Gary,’ and Jonquiere above. Evidence was given to the Committee on the effect of the practice of assisted suicide on the medical practitioners involved and the result of desensitisation and the risk this presents for vulnerable patients at end of life

*It is hardwired into us that we do not kill each other. A doctor particularly, who has been trained to care for people—even Nitschke talks about how he felt after the first people he killed, and he is passionate, he believes he is doing the right thing. There certainly have been doctors in the Netherlands who did some euthanasias and then stopped. It is a very hard thing that we ask doctors to do if we make a law defending euthanasia...A doctor who is repeatedly giving lethal injections to patients and seeing the patients die in front of them becomes inured to that. I am not blaming them if that is the legal system and they do it, but that happens to them. It is not surprising then that in 2015, in the next round of five-year detailed studies, they found that*

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437 Stahle F (2017) ‘Moral disengagement – Mechanisms Propelling the Euthanasia/PAS Movement,’ *Journal of Ethics in Mental Health* 10 at 7 referring to Stevens KR (2006) ‘Emotional and psychological effects of physician-assisted suicide and euthanasia on participating physicians’ *Issues Law Med* 21(3) 187-200.

438 Stahle F (2017) ‘Moral disengagement – Mechanisms Propelling the Euthanasia/PAS Movement,’ *Journal of Ethics in Mental Health* 10 at 8.



*there were 431 people killed in the Netherlands by direct action by a doctor with the explicit intention of ending their life—no request.*<sup>439</sup>

- 2.249. The desensitisation of medical practitioners if assisted suicide were legalised in Western Australia would heighten the other risks to vulnerable patients as already outlined in this Report.

### **Wounded healers**

- 2.250. It was revealed in a 2013 report that doctors reported substantially higher rates of psychological distress and attempted suicide than both the general Australian population and other professionals, with 21 per cent having been diagnosed with or treated for depression.<sup>440</sup> Dr Michael Gannon, then AMA President, said ‘there would be a very, very small number of doctors who haven’t been touched by the suicide of a colleague, either at medical school or as a doctor.’<sup>441</sup> In her article ‘Wounded healers’, Sharon Verghis asks ‘Is there something unique in the psychological makeup of doctors that puts them at higher risk of mental illness and suicide?’

*Yes, Myers concludes... First, there’s what he calls the “wounded healer” hypothesis of psychoanalyst Carl Jung. People drawn to medicine, Myers says, are often simultaneously the right people and the wrong people for the role. Many, he told LitMed, are “survivors of childhood trauma, loss and family dysfunction. [They] make great doctors but can be vulnerable to psychiatric symptoms either genetically or from their early environment.” The traits that help them excel in their profession—altruism, empathy, sensitivity to the pain of others—can prove to be pitfalls, says Myers. “We look for sensitivity in applicants to medical school and residencies and it is frightening to think that so positive an attribute can be part of the volatile mix that leads to suicide in distressed doctors.” Add to this a tendency to perfectionism.*<sup>442</sup>

- 2.251. The higher rates of psychological distress and suicide in the medical profession is of serious concern, not only for the wellbeing of medical students and professionals, but also for the conflict this presents in a legalised assisted suicide framework where doctors are to be the ‘safeguards’ against vulnerable patients accessing assisted suicide.
- 2.252. It has been said that there is an urgent need for reform of college exam processes and possible amendments to mandatory reporting laws, along with more doctor-focused

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439 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Transcript, 9 March 2018, Session 1 at 9.

440 beyondblue, National Mental Health Survey of Doctors and Medical Students, October 2013  
<[https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report\\_web](https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web)>

441 Sharon Verghis, ‘Wounded healers,’ *The Australian*, 5 May 2018.

442 Ibid.

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counselling services and hospital-based wellness programs. A comprehensive strategy across prevention, early intervention and crisis intervention for the whole profession is required.<sup>443</sup>

### **Finding 62**

The emotional and psychological effects on medical practitioners participating in assisted suicide are substantial and consequential.

### **Finding 63**

The desensitisation of medical practitioners by participation in assisted suicide exacerbate the risk that already exists due to doctor bias.

### **Finding 64**

The rate of psychological distress and attempted suicide by medical practitioners is high.

### **Recommendation 12**

The Minister for Mental Health should direct the Mental Health Commission to develop, in consultation with medical practitioners and the Department of Health, a comprehensive mental health strategy for prevention, early intervention and crisis intervention for the whole of the medical profession.

## **Assisted Suicide Cannot Guarantee a ‘Good Death’**

- 2.253. Proponents of assisted suicide suggest that the inability of palliative care to address the refractory symptoms of a small minority of people suffering from a terminal condition in the dying phase necessitates the legalisation of assisted suicide. The suggestion is made that palliative care cannot provide a ‘good death’ for *all* individuals, and that, by contrast, assisted suicide can and is therefore required.
- 2.254. Doctors for Assisted Dying Choice list their criteria for a ‘good death’ as
- *To know when death is coming, and to understand what can be expected*
  - *To be able to retain control of what happens*
  - *To be afforded dignity and privacy*
  - *To have control over pain relief and other symptom control*
  - *To have time to say goodbye, and control over other aspects of timing; and*
  - *To be able to leave when it is time to go, and not to have life prolonged pointlessly<sup>444</sup>*
- 2.255. Doctors for Assisted Dying Choice also assert that members of the medical profession have a duty to respond to patient’s needs since they ‘have the means and skills to provide

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443 Recommendations made in Sharon Verghis, ‘Wounded healers,’ *The Australian*, 5 May 2018.

444 Doctors for Assisted Dying Choice, JSCEOLC Submission 402 at 1.

a gentle death’ and ‘a duty to ensure that the duration of [a patient’s] suffering is as short as possible.’<sup>445</sup> They refer to the use of ‘best practice protocols’ regarding ‘medication that is reliable’, and that ‘Nembutal solution is the gold standard for oral use and should be made available.’<sup>446</sup> Similar statements were made in evidence in Committee hearings. Mr Hindle, President of Dying with Dignity (WA) suggested that ‘Nembutal is the way to go. I am not aware of anybody who has taken Nembutal who has not succeeded in what they set out to do.’<sup>447</sup> After criticising the efficacy of palliative sedation (noting here the unsoundness of this criticism—as already considered in Chapter 1—Palliative Sedation), Dr Beahan of Doctors for Assisted Dying Choice states

*By contrast, voluntary assisted dying in those who request it is quick, painless and certain.*<sup>448</sup>

- 2.256. In contrast to these absolute statements, some proponents of assisted suicide did acknowledge that complications with medication do in fact arise in assisted suicide, but sought to minimise or downplay the frequency of this occurrence and the impact on the individual involved:

*[Complications with the use of Nembutal] are rare and I guess you would have heard from Dignitas because they have almost more experience than anyone in the world over the use of that drug. Taken as a drink, orally—that is, by mouth—it is a very effective drug. To say that there have never been complications, though, there is an aphorism in medicine which I remember: never say never, because there are exceptions to everything, and there is always some example somewhere in the world where things did not go according to plan. I am sure that there are—of course, I have read of some—experiences where the drug did not do exactly what it was supposed to do.*<sup>449</sup>

*So there have been instances of people waking up, and one only—I think it is elaborated on later in the article—had some problems associated with it. Sorry; there is another paragraph and I had seen it. But, overall, any incidence of that sort of thing is very low indeed... in Oregon the model is the prescription is there, the patient deals with it themselves, and problems have been very few and far between ... Nothing is perfect, but these articles are highly reassuring, I would suggest, in describing how it happens in Oregon.*<sup>450</sup>

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445 Ibid.

446 Ibid at 12.

447 Mr Hindle, President, Dying with Dignity (WA), JSCEOLC Transcript, 13 April 2018, Session 5 at 7.

448 Dr Beahan, Doctors for Assisted Dying Choice, JSCEOLC Transcript, 26 February 2018, Session 4 at 6.

449 Dr Nitschke, Exit International, JSCEOLC 13 April 2018, Session 1 at 8.

450 Mr Walker, Vice President, Dying with Dignity (WA), JSECOLC 13 April 2018, Session5 at 7-8.

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2.257. Dignitas of Switzerland, also gave evidence that:

*For the past 20 years, we have done over 2 500 accompanied suicides and we have a zero fail rate. The thing is, you have to know—you have to have know-how—not necessarily a lot of medical know-how, but you have to have know-how how to handle pentobarbital and what to expect... when you have the know-how, there is a zero fail rate.<sup>451</sup>*

2.258. Indeed, Dignitas went on to suggest that no complications exist in assisted suicide deaths as all possible problems or complications are thought of in advance and therefore avoided:

*Hon NICK GOIRAN: When you say that you have been involved in some many years ago, how many is some?*

*Mr LULEY: I think it was three or four cases.*

*Hon NICK GOIRAN: Would you be in a position to tell the committee if there were any complications that you witnessed during those three or four that you are involved in?*

*Mr LULEY: There were no complications, and this relates to the earlier question on the application, the ingestions of pentobarbital—whether there is a failure rate. There is no failure rate, because we have the know-how to handle the pentobarbital. We know how to handle it and instruct the patients what to do. There is no problem.*

*Hon NICK GOIRAN: I remember you mentioned earlier that you had worked out a technique to shift the patient to ensure that the drug went into the intestines. How did you find out about this technique?*

*Mr LULEY: We have a kind of advisory committee which includes lawyers and medical doctors. They are not on the board; it is like an advisory committee of Dignitas. One of them was an elderly medical doctor, and he brought up that idea, and said that it could be possible that there are rare patients with an anomaly in the stomach-intestine connection, pylorus I think it is called called—an anomaly in the stomach. It is rare, but it does exist. He said if ever there is a situation of a patient being comatose, but the effect of the pentobarbital is not taking its effect, we simply shift the body. When we first had a case like that, where it took about one and a half hours and the patient was still lying on the bed and still sleeping—unconscious—we moved the body to one side and within*

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<sup>451</sup> Mr Luley, Board member, Dignitas, Switzerland, JSCEOLC Transcript, 8 March 2018, Session 5 at 2-3.

*a quarter of an hour, the patient passed away. It was an idea by a doctor that it could be that. We tried and realised it worked.*

*Hon NICK GOIRAN: Yes, okay, so I think, if I understand you, you are saying that this advisory panel and this doctor had given advance thought to a problem that could arise, and had developed a solution before the problem arose.*

*Mr LULEY: That is correct. I would not be able to say if the problem had arisen earlier before Dignitas was [inaudible] with Exit, whether they earlier on had an issue with that. We had the know-how and we applied it. I think it is probably just a dozen cases of the 2 500, as far as I can see, that our team encountered the issue.<sup>452</sup>*

- 2.259. Meanwhile in another Committee hearing the complications with Nembutal were described this way by Dr Alida Lancée, Doctors for Assisted Dying Choice:

*Hon NICK GOIRAN: Dr Lancée, in response to the question from my colleague Mr McGrath you raised nembutal. I note that your submission also refers to it as being the gold standard. What are the complications with nembutal?*

*Dr LANCÉE: The complications—in terms of—well, the complication would be that it is very bitter and it is very difficult to self-ingest. Complications in terms of whether it has the outcome that the patient wishes, there is a potential that it may lead to a protracted uncertain duration that it takes from ingestion until death, and I think in Oregon there was one person who actually woke up again, so needed to have the injection as a backup to allow them to stop their suffering.<sup>453</sup>*

- 2.260. However, the actual evidence of the incidence rate of complications in Oregon directly contradicts the evidence given by Dr Lancée and others. The suggestion that only one person in Oregon has woken again after the administration of Nembutal, and that they ‘needed to have a further injection as a back up to allow them to stop their suffering’ is incorrect as the reporting data from Oregon outlines quite a different picture:

*In 2016 one in nine (8.1%) (sic.) of those for whom information about the circumstances of their deaths is available either had difficulty ingesting or regurgitated the lethal dose... from 2010 reports of complications were only recorded if a physician was present at the time*

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452 Mr Luley, Board member, Dignitas, Switzerland, JSCEOLC Transcript, 8 March 2018, Session 5 at 5-6, including information provided by the witness to the Committee clarifying the transcript.

453 Dr Lancée, Medical Practitioner, Doctors for Assisted Dying Choice, JSCEOLC Transcript, 2 March 2018, Session 3 at 9.

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*of administration so percentages for complications artificially decline as complications are listed as “unknown” for the majority of cases in which no physician was present.*<sup>454</sup>

- 2.261. The interval from ingestion of lethal drugs to unconsciousness has been as long as one hour while the interval from ingestion to death has ranged from 1 minute to as long as 104 hours (4 days and 8 hours).<sup>455</sup> In 2005, ‘One patient became unconscious 25 minutes after ingestion, then regained consciousness 65 hours later. This person did not obtain a subsequent prescription, and died 14 days later of the underlying illness (17 days after ingesting the medication).’<sup>456</sup> This case was patient David Prueitt who, after ingesting the prescribed barbiturates spent three days in a deep coma, then suddenly woke up, asking his wife ‘Honey, what the hell happened? Why am I not dead?’ David survived for another 14 days before dying naturally from his cancer.<sup>457</sup>
- 2.262. Since 2005 five other people have regained consciousness after ingesting the lethal medication:

*‘In 2010, two patients regained consciousness after ingesting medications. One patient regained consciousness 88 hours after ingesting the medication, subsequently dying from underlying illness three months later. The other patient regained consciousness within 24 hours, subsequently dying from underlying illness five days following ingestion. In 2011, two patients regained consciousness after ingesting the medication. One of the patients very briefly regained consciousness after ingesting the prescribed medication and died from underlying illness about 30 hours later. The other patient regained consciousness approximately 14 hours after ingesting the medication and died from underlying illness about 38 hours later.’*<sup>458</sup>

*In 2012 ‘one patient ingested the medication but regained consciousness before dying of underlying illness ... The patient regained*

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454 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 31-21, citing Oregon Public Health Division, ‘Oregon Death With Dignity Act: Data Summary 2016, Table 1. Characteristics and end-of-life care of 1,127 DWDA patients who have died from ingesting a lethal dose of medication as of January 23, 2016 [sic = 2017], by year,’ Oregon, 1998-2016 at 10.

455 Ibid at 11.

456 Oregon Department of Human Services, Office of Disease Prevention and Epidemiology (2006) Eighth Annual Report on Oregon’s Death with Dignity Act at 14.

457 ‘Oregon man wakes up after assisted-suicide attempt,’ Seattle Times, 4 March 2005.

458 Oregon Health Authority, Death With Dignity Act, Year 14 - Table 1, Characteristics and end-of-life care of 596 DWDA patients who died after ingesting a lethal dose of medication as of February 29, 2012, by year, Oregon, 1998-2011, footnote 12 at 6.

*consciousness two days following ingestion, but remained minimally responsive and died six days following ingestion.*<sup>459</sup>

- 2.263. These are the cases we do know about. As Mr Egan points out (above), from 2010 the percentages for complications artificially decline as complications are listed as ‘unknown’ for the majority of cases in which no physician was present. Blank et al also note that information on drug effectiveness and complications was requested on all patients from 1998 to 2010, but that after that only cases where a health care provider was present at the time of death were obtained.<sup>460</sup> That these patients were left to die alone, at risk of complications without the presence of a medical professional, stands in stark contrast to the assertion of Doctors for Assisted Dying Choice that assisted suicide should be legalised as ‘doctors have a duty to respond to [a] patient’s needs’ and ‘have the means and skills to provide a gentle death’ and a ‘duty to ensure that the duration of this suffering is as short as possible.’<sup>461</sup>
- 2.264. Emanuel et al note that ‘There are no flawless medical procedures; all procedures and interventions can have complications. Determining the rate of problems and complications related to euthanasia and PAS has been challenging because of definitions and the lack of witnesses.’<sup>462</sup> They state that:

*For several years, Oregon reported no complications. Between 1998 and 2015 (average number of deaths per year, 55), Oregon reported absence of data on complications for 43.9% of cases, no complications for 53.4% of cases, and regurgitation of medication in 2.4% of cases as the sole complication. The state reported that between 2005 and 2012, 6 patients (0.7%) regained consciousness after ingesting the lethal medications but paradoxically does not classify this as a complication. The median time between ingestion of barbiturate and death was 25 minutes, but the range extends to 104 hours—more than 4 days. The number of prolonged deaths—those taking longer than a day—is not reported in Oregon.*<sup>463</sup>

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459 Oregon’s Death With Dignity Act—2012 Table 1, Characteristics and end-of-life care of 673 DWDA patients who died after ingesting a lethal dose of medication as of January 14, 2013, by year, Oregon, 1998-2012 at 2.

460 Blanke et al (2017) ‘Characterizing 18 Years of the Death With Dignity Act in Oregon,’ *JAMA Oncol* 3(10) 1403-1406.

461 Dr Alida Lancée, WA State Convenor, Doctors for Assisted Dying Choice, JSCEOLC Submission 402 at 1.

462 Emanuel et al (2016) ‘Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada and Europe’ *JAMA* 316(1) 79-90 at 86 (emphasis added).

463 Ibid (emphasis added).

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- 2.265. On the data on patient deaths from Oregon that the interval from ingestion of lethal drugs to death has ranged from 1 minute to as long as 104 hours, evidence was given to the Committee that:

*One example of this lack of knowledge is the reported range of time between ingestion and death, which the OHA 2017 Data Summary indicates has been from 1 minute to 104 [hours]. Death is unlikely within 1 minute of taking the sedatives when the patient is sufficiently well to self administer. Likewise, the effect of the short-acting sedatives would have dissipated by (say) 24 hours at best. It is unclear how death occurred. It can however be stated with some measure of certainty that in some of these “death with dignity” instances, people experienced suffering over and above that of their terminal illness.<sup>464</sup>*

- 2.266. Evidence of the clinical procedures for assisted suicide was also provided to the Committee:

*I have seen also the clinical procedure for, I think, Oregon in the United States, where it is death by lethal injection, and in that circumstance it is a course of three different types of drugs injected over a period of time. It is extremely distressing, actually, just to read the clinical procedure, because it is things like, if there are any carers in the room for the individual, warn them that after this injection the individual may be gasping for breath, may suffer a cardiac arrest. It also contemplates that the timing of death may be up to 24 hours. It is very difficult to kill a human being; there is not a nice easy one-size-fits-all approach.<sup>465</sup>*

- 2.267. Evidence of complications also exists from Washington State. In relation to which drug should be used, there is evidence from Washington State that:

*The first Seconal alternative turned out to be too harsh, burning patients’ mouths and throats, (p34) causing some to scream in pain. The second drug mix, used 67 times, has led to deaths that stretched out hours in some patients — and up to 31 hours in one case. [Twenty per cent] of the cases were 3 hours or more before death, which we think is too long,” said Robert Wood, a retired HIV/AIDS researcher who volunteers with the advocacy group End of Life Washington, in an email. The longest was 31 hours, the next longest 29 hours, the third longest 16 hours and some 8 hours in length. “Patients and families are told to expect sleep within 10 minutes and death within four hours.*

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464 Ms Re, Chief Executive Officer, IdentityWA, Response to Questions on Notice, 10 April 2018 at 3.

465 Mrs Greenwood, Chief Executive, Catholic Health Australia, JSCEOLC Transcript, 28 February 2018, Session 1 at 9.



*When it takes far longer, family members get worried, even distressed, said Dr. Carol Parrot, a retired anesthesiologist who has prescribed drugs for dozens of aid-in-dying patients in Washington. Doctors recently began using the newest drug mixture and will gather data about its effectiveness.<sup>466</sup>*

2.268. Emanuel et al note that:

*In Washington state, for 2014 and 2015 combined, the data are less complete. For the 292 reported cases, 1.4% of patients regurgitated the medications, and 1 patient experienced a seizure. It is unclear if any patients in Washington state regained consciousness. Only 66.8% of patients died in less than 90 minutes, while the range extends to 30 hours.<sup>467</sup>*

2.269. Emanuel et al also refer to complications in the Netherlands:

*A comprehensive 2000 study of problems and complications in 649 Dutch cases (prior to the actual legalization) revealed a higher frequency of problems with [physician-assisted suicide] than with euthanasia. Technical problems with PAS, such as difficulty swallowing, occurred in 9.6% of cases, and complications such as vomiting or seizures occurred in 8.8% of cases. In 1.8% of PAS cases, patients awoke from coma and in 12.3% of cases time to death was longer than anticipated or the patient never became comatose. For euthanasia, 4.5% of cases had technical problems, such as inability to find a vein for injection, and in 3.7% of cases patients had complications such as vomiting, ormyoclonus. In 0.9% cases patients awoke from coma, and in 4.3% of cases time to death was longer than expected or the patient did not become comatose. These data are 16 years old, and 13 years of legalization may have reduced the complication rate.<sup>468</sup>*

2.270. The suggestion that 13 years of legalisation in the Netherlands may have reduced the complication rate is not supported by the more recent evidence from Oregon and Washington.

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466 JoNel Aleccia 'Docs In Northwest Tweak Aid-In-Dying Drugs To Prevent Prolonged Deaths' *Kaiser Health News*, 21 February 2017 (<https://khn.org/news/docs-in-northwest-tweak-aid-in-dying-drugs-to-prevent-prolonged-deaths/>), quoted by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 33-34.

467 Emanuel et al (2016) 'Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada and Europe,' *JAMA* 316(1) 79-90 at 86.

468 Ibid.

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- 2.271. Emanuel et al refer only to complication statistics in Oregon, Washington and the Netherlands and state ‘There are no data from other countries, including Belgium, on problems or complications with euthanasia or PAS.’<sup>469</sup>
- 2.272. What data we do have available to us on complications in assisted suicide practice from Oregon, Washington and the Netherlands directly contradicts the assertions from proponents cited above that complications either do not exist at all or are rare. To those proponents who are intellectually honest enough to acknowledge that complications do occur, but then seek to downplay or minimise the relevance of such complications, law Professor Quinlan’s discussion on the *raison d’être* of assisted suicide is instructive:

*Complications in administering capital punishment by lethal injection are unacceptable. It must however be remembered that the purpose of capital punishment is primarily the death of the convicted criminal. One of the *raison d’être* of euthanasia is different. It is securing a “good death.” This means that complications in administering euthanasia are not only unacceptable; where this is the procedure’s objective, they undermine its foundational purpose. Forty years of capital punishment by lethal injection and the international experience of euthanasia by this means suggest that complications may be inevitable and militate against the legalisation of euthanasia in Australia for this reason.*<sup>470</sup>

- 2.273. Deaths by assisted suicide are not all ‘quick, painless and certain’ as proponents would like us to believe, nor do doctors have the means and skills to *always* provide a ‘gentle death’ or ‘good death’ and a doctor *cannot* ‘ensure that the duration of a patient’s suffering is as short as possible.’

### Finding 65

Evidence of complication rates of physician assisted suicides in Oregon until 2010 are troubling. Complication rates after 2010 artificially declined as from this time reports of complications were only recorded if a physician was present at the time of administration.

### Finding 66

Evidence of complication rates in Washington are equally troubling with multiple instances of regurgitation, one-third of patients taking in excess of one and a half hours to die, at least one patient suffering a seizure and another taking 30 hours to die.

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469 Emanuel et al (2016) ‘Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada and Europe’ *JAMA* 316(1) 79-90 at 86.

470 Quinlan M (2016) “‘Such is Life’: Euthanasia and capital punishment in Australia: consistency or contradiction?’ *Solidarity: The Journal of Catholic Social Thought and Secular Ethics* 6(1) at 18 (emphasis added).

**Finding 67**

Decades of experience in administering capital punishment, euthanasia and assisted suicide indicate complications are inevitable and this alone ought to militate against legalisation in Western Australia.

**Trading Lives**

2.274. Chapter 2 of this Report has identified many areas of risk in the legalisation of assisted suicide, including:

- The complexity in assessment of competence and that it cannot be ensured that patients suffering from mental illness, including depression and demoralisation, will not be euthanised;
- The risk in determining that a patient has given informed consent;
- The risk that a patient's consent may not be voluntary, but subject to undue influence and the risk this especially poses to patients already vulnerable to elder abuse;
- Increased risk to people living with disabilities, who already suffer discrimination in the health care system;
- An inherent conflict with existing suicide prevention programs;
- Evidence that assisted suicide may deter certain patients from accessing conventional palliative care services;
- Risk to the wellbeing of the medical practitioners involved in the provision of assisted suicide;
- The inevitability of casualties arising from error rates in misdiagnosis and prognosis; and
- Complications involved in the procedure itself.

2.275. Proponents point to studies that have sought to measure vulnerability to risk in assisted suicide, such as the study conducted by Battin et al, who after examining data from Oregon and the Netherlands, concluded that there was no evidence that vulnerable people, except for people with AIDS, are euthanised more disproportionately than others.<sup>471</sup> 'Vulnerable' was defined in the study as individuals who are elderly, female, uninsured, of low education status, poor, physically disabled or chronically ill, younger

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471 Battin et al (2007) 'Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups,' *J Med Ethics* 33, 591–7.

## Chapter 2

than the age of majority, affected with psychiatric illnesses including depression, or of a racial or ethnic minority. A study of the demographic profile of patients in the United States revealed that those who have received assisted suicide interventions are white, well-educated and well insured.<sup>472</sup> Arguably these studies have failed to measure vulnerability to risk. These studies can be challenged on the basis that vulnerability to assisted suicide cannot be categorised simply by reference to race, sex, or other socioeconomic status.<sup>473</sup> Finlay and George suggest that there are other characteristics, that are individual to each patient and extend beyond the macro-categorisations of demography, such as emotional state, reaction to loss, personality type and the sense of being a burden, that are also important.<sup>474</sup> Patients are also vulnerable to the level of training and experience that their physicians have in palliative care and to the personal views of their physicians about the topic, as a study has shown that the more physicians know about palliative care, the less they favour assisted suicide.<sup>475</sup> That an individual is white, well-educated and well insured, also does not mean that that individual would not be susceptible to the risks listed above.

2.276. It cannot be guaranteed that a person suffering from mental illness or demoralisation will not be euthanised. It cannot be guaranteed that a person will have been offered specialist palliative care services in order to make an informed choice to proceed with assisted suicide. It cannot be guaranteed that the consent of every patient requesting assisted suicide is voluntary and free of undue influence. It cannot be guaranteed that a person without a terminal illness, or with a prognosis of many years to live, will not be euthanised. It also cannot be guaranteed that the legalisation of assisted suicide will ensure a 'good death,' free of complications, for all patients. What can be guaranteed is that an assisted suicide regime will always result in casualties.

2.277. Dr Khorshid advised the Committee that:

*nowhere are the safeguards perfect because the innate nature of these discussions means that there is always uncertainty. There is uncertainty about prognosis, there is uncertainty about competence, there is uncertainty about family dynamics and, as I mentioned before,*

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472 Emanuel et al (2016) 'Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada and Europe,' *JAMA* 316(1) 79-90 at 87.

473 Pereira J (2011) 'Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls,' *Current Oncology* 18(2), 38-45 at 42.

474 Finlay and George (2011) 'Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the impact on patients in vulnerable groups--another perspective on Oregon's data,' *J Med Ethics* 37(3) 171-4.

475 Pereira J (2011) 'Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls,' *Current Oncology* 18(2), 38-45 at 42.

*coercion... Any system that you put in has limitations on how effective it can be at ensuring that rules are being followed.*<sup>476</sup>

2.278. Thus, the question must be asked, how many such individuals is our society prepared to sacrifice as the collateral damage from the legalisation of assisted suicide?<sup>477</sup>

2.279. Mr Egan suggests that the test as to whether to introduce legalised assisted suicide in Western Australia is analogous to the reintroduction of capital punishment:

*Many people hold the view that capital punishment may be justified in a particularly horrific case. However, such people may still reject the reintroduction of capital punishment because they are not convinced that any proposed regime can ensure that not even a single innocent person is put to death wrongly by the State. The same test should be required for any regime claiming a safe approach to assisting the suicide of certain Western Australians.*<sup>478</sup>

*I believe that the proper test for a law permitting assisted suicide or euthanasia is the one that many of you would apply to any proposal to reintroduce capital punishment, perhaps in the light of some horrific new murder, serial killer or rapist... That test is: can we craft a law that will ensure there will not be even one wrongful death? I do not believe we can.*<sup>479</sup>

2.280. The burden of proof is on those advocating for a change in the law to establish that such a profound change would be safe for the whole community.<sup>480</sup> Proponents of assisted suicide have not met this burden.

2.281. Mr Laurence Van Der Plas, Research Officer for the Association for Reformed Political Action, offered a similar test, applying assisted suicide to the risk matrix used in the fire and rescue service:

*When I was a volunteer in the fire and rescue service, one of the things we had was this whole idea that if there is a bushfire, do people stay*

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476 Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, Session 1, 18 May 2018 at 17, paraphrasing evidence given at the recent AMA(WA) Symposium on End of Life Choices by Professor Finlay, Co-Chair, Living and Dying Well.

477 M Golden, 'Why assisted suicide must not be legalized,' Disability Rights Education and Defence Fund,' <<https://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/>> quoted in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 29.

478 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 35. See also Dwight Randal, President, Coalition for the Defence of Human Life, JSCEOLC Response to Questions on Notice, 17 April 2018 at 10.

479 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Transcript, 9 March 2018, Session 1 at 2.

480 Ibid at 1.

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*and defend their homes or do they go? That is the question: what do you do? What you do is you say, "In each situation, whether I stay and defend or whether I go, what is the best outcome and what is the worst outcome?" The best outcome if you stay and defend your house, is that the fire passes your house or you manage to defend it and your house is safe. Whether you go, the best outcome is actually same. The fire passes your house; the fire brigade gets it; it is all good. What is the worse outcome in each state? The worst outcome if you go early, is that your house is burnt up. You are safe, but you lose your house. What is the worst possible outcome if you stay and defend? The worst outcome is you die. On that basis alone people are told: go. At least your life is safe. If you transpose that across to assisted dying, the best possible outcome for every Western Australian if we do not legalise assisted dying is a peaceful death—that is the best possible outcome in both cases. What is the worst possible outcome? The worst possible outcome if we do not allow assisted dying, is that some people may die a painful death. We grant that. What is the worst possible outcome if we do allow assisted dying? The worst possible outcome is that someone who does not need to die inadvertently does. That is what we mean by the risk assessment. Under that matrix, the worst possible outcome is far worse under assisted dying. That is a death that did not have to occur or should not have occurred.<sup>481</sup>*

- 2.282. In 2010, a report from the Victorian Institute of Forensic Medicine considered the cases of 51 people who died from Nembutal in Australia. The report found that young people and depressed people were more likely to die by Nembutal than terminally ill people in Australia. Dr Nitschke's response to this finding in the Victorian report was that 'There will be some casualties... but this has to be balanced with the growing pool of older people who feel immense well-being from having access to this information.'<sup>482</sup>
- 2.283. Dr 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?'<sup>483</sup>

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481 Mr Van Der Plas, Research Officer, Association for Reformed Political Action, JSCEOLC Transcript, 8 March 2018, Session 3 at 8-9.

482 Julia Medew 'Young people gain access to euthanasia drug,' *Sydney Morning Herald*, 15 February 2010 <<https://www.smh.com.au/lifestyle/health-and-wellness/young-people-gain-access-to-euthanasia-drug-20100215-nzon.html>> (emphasis added).

483 Dr Henry Marsh quoted in 'Henry Marsh: The Do No Harm author on the secrets of brain surgery,' *The Times*, 23 April 2017 <<https://www.thetimes.co.uk/article/i-had-to-tell-the-family-her-death-had-been-avoidable-they-still-thanked-me-hvv6jgnnj>> and quoted by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Transcript, 9 March 2018, Session 1 at 2 (emphasis added).

2.284. Mr Egan calls this ‘trading lives:’

*[I]f you make a law based on a small number of hard cases, unless you can be sure that the law you craft is only going to apply to that small number of hard cases, then you are essentially trading lives. Some people are going to die prematurely... in order to try to relieve the particular pain or difficulty of other people.<sup>484</sup>*

2.285. In evidence to the Committee, Rev Saunders stated that ‘the objective deleterious effects of laws allowing assisting suicide and euthanasia significantly outweigh any perceived subjective benefits.’<sup>485</sup>

2.286. Similarly, ‘[i]f these laws have a deleterious effect on palliative and end-of-life care, and on suicide prevention efforts, in the general population of the states enacting them, the number of people (including seriously ill people) adversely affected by them vastly exceeds the number of patients who actually make use of the “aid in dying” option.’<sup>486</sup>

2.287. Former Prime Minister, Mr Paul Keating stated:

*An alarming aspect of the debate is the claim that safeguards can be provided at every step to protect the vulnerable. This claim exposes the bald utopianism of the project—the advocates support a bill to authorise termination of life in the name of compassion, while at the same time claiming they can guarantee protection of the vulnerable, the depressed and the poor. No law and no process can achieve that objective. That is the point.*

...

*It is true that if this bill fails then some people will endure more pain and this is difficult for legislators to contemplate. It is also true, however, that more people in our community will be put at risk by this bill than will be granted relief as its beneficiaries. This is the salient point... The issue is not how many people will choose to die under this proposed law. It is how many people may die when otherwise they wouldn’t.*

...

*Opposition to this bill is not about religion. It is about the civilisational ethic that should be at the heart of our secular society. The concerns I*

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484 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Transcript, 9 March 2018, Session 1 at 2.

485 Rev Saunders, National Director, FamilyVoice Australia, JSCEOLC Transcript, 9 March 2018, Session 3 at 8.

486 R Doerflinger (2017) ‘The Effect of Legalizing Assisted Suicide on Palliative Care and Suicide Rates: A Response to Compassion and Choices,’ *On Point* 13 at 7.

## Chapter 2

*express are shared by people of any religion or no religion. In public life it is the principles that matter. They define the norms and values of a society and in this case the principles concern our view of human life itself. It is a mistake for legislators to act on the deeply held emotional concerns of many when that involves crossing a threshold that will affect the entire society in perpetuity.*<sup>487</sup>

- 2.288. Mr Denton suggests that '[w]hat we are looking to do is create a law which mitigates harm in the community.'<sup>488</sup> Mr Denton also suggests that to be on the anti-euthanasia side of the debate means to be deliberately ignorant of the suffering of others— 'Opponents to this law make every effort to drown out [the voices of the terminally ill] in this debate. Look straight past them. Pretend their stories never happened,' drowning out the voices of 'the most vulnerable in our society, those most in need of our compassion and protection.'<sup>489</sup>
- 2.289. Assisted suicide laws in Western Australia will not mitigate harm in the community. Assisted suicide laws in this State will expose Western Australians to the very real risk of premature and wrongful death. To support assisted suicide is to be ignorant of the impact that the lifting of the prohibition on one person deliberately killing another would have on Western Australia, particularly on the most vulnerable members of our community, including the terminally ill, the mentally ill, the disabled and the elderly. If that ignorance is not present then such proponents have determined that the trading of lives is acceptable.
- 2.290. Autonomy and choice are important values in any society, but they are not absolutes. The decision for lawmakers is ultimately this:

*You have a choice: to make euthanasia available for the small number of people who want to choose the timing and manner of their own death; or you can choose to protect those people at risk of dying when they do not really want to, if a law is passed. Personally, I do not think that government exists to support the autonomy for the few at the cost of the security of the vulnerable. Mahatma Gandhi said, "The calibre of a society lies in how it treats its most vulnerable members."*<sup>490</sup>

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487 Paul Keating, 'Voluntary euthanasia is a threshold moment for Australia, and one we should not cross,' *Sydney Morning Herald*, 19 October 2017.

488 Mr Denton, *Go Gentle Australia*, JSCEOLC Transcript, 13 April 2018, Session 6 at 9-10.

489 Mr Denton, *Go Gentle Australia*, JSCEOLC Submission 539 at p8.

490 Dr Best, *Palliative Care Physician and Academic*, JSCEOLC Transcript, Session 2, 1 May 2018 at 3.



**Finding 68**

The onus is on those advocating for a change in the law to establish that such a profound change will be safe for the whole community. Anything less results in nothing more than the trading of lives.

**Finding 69**

The best possible outcome in an assisted suicide regime is that a person who was dying, dies sooner than they would have. The worst possible outcome in an assisted suicide regime is a wrongful death.



## Chapter 3

### Lessons Learned from Other Jurisdictions

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The clinical experience observed during the brief life of the ROTI Act [euthanasia legislation in the Northern Territory] could be regarded as an experiment in which the legislation that supported the practice of euthanasia can be examined for its effectiveness. This [clinical experience] ...demonstrated the inadequacy of provisions of the ROTI Act and suggested that the vulnerable cannot be safely protected by such legislation.

Prof David Kissane AC MD<sup>491</sup>

**There is no redress for family or friends in the event that a death was hastened and one or more of the eligibility requirements was not met. Obviously one cannot be brought back from the dead.**

Marshall Perron, former Chief Minister of the Northern Territory,  
who sponsored the Rights of the Terminally Ill Act 1995<sup>492</sup>

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- 3.1. It was asserted to the Committee that 'repeated, independent, peer-reviewed, and exhaustive, reviews have shown no evidence of abuse of the vulnerable overseas.'<sup>493</sup>
- 3.2. Dr Lancée, Doctors for Assisted Dying Choice, suggests that:

*We have the benefit of being able to learn from the experience of other jurisdictions over several decades. We can check the multitude of reports and reviews about the problems they faced and we can feel reassured that none of the dreaded fears of elder abuse, coercion, death-thirsty doctors, slippery slopes or degradation of palliative care have been realised in places where voluntary assisted dying is legal.<sup>494</sup>*

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491 Professor David W Kissane, MD is an academic psychiatrist, psycho-oncology researcher and author. He is currently the Head of Psychiatry for Monash University in Australia, recently the Chairman of the Department of Psychiatry and Behavioral Sciences at Memorial Sloan-Kettering Cancer Center in New York and previously the Foundation Chair of Palliative Medicine at the University of Melbourne. He was also made a Companion of the Order of Australia in January 2018 for his contribution to the field of psycho-oncology and palliative medicine as an educator, researcher, author and clinician. Quote taken from Kissane DW (2000) 'The Challenge of Informed Consent,' *Journal of Pain and Symptom Management* 19(6), 473-4 at 474.

492 Mr Marshall Perron, Private Citizen, JSCEOLC Response to Questions on Notice, undated.

493 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 42.

494 Dr Lancée, Medical Practitioner, JSCEOLC Transcript, Session 6, 5 April 2018 at 7.

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- 3.3. Mr Marshall Perron, former Chief Minister of the Northern Territory, and architect and sponsor of the *Rights of the Terminally Ill Act 1995* (NT) (ROTI Act), writes:

*It has been clearly shown that responsible, safe laws can be drafted that allow willing doctors to respond to requests for early termination of life made by a competent adult. Experience elsewhere demonstrates there are a number of models that work, each of them differing in regard to eligibility, pre-conditions to be met and the form of assistance that can be provided.*<sup>495</sup>

- 3.4. Professors White and Willmott also gave evidence to the Committee that the claim is made by opponents of assisted suicide:

*that the law will inevitably expand over time to allow new and broader groups to have access to assisted dying. But this factual claim doesn't reflect what has happened elsewhere. There have been virtually no changes in the regimes that permit assisted dying overseas.*<sup>496</sup>

- 3.5. Similarly, Mr Denton observed that

*It is not that people don't campaign for or talk about changes, they do and will always do it as part of a democratic society, but the notion that once a law for voluntary assisted dying is passed, it will invariably change is simply not supported by the evidence from overseas jurisdictions.*<sup>497</sup>

- 3.6. Great emphasis was also placed by proponents on the decision of the Supreme Court of Canada in *Carter v Canada (Attorney General)*,<sup>498</sup> where it was said the Court 'looked at all the available peer-reviewed evidence itself and concluded that there was no evidence that people who were vulnerable were at risk under the assisted dying legislation.'<sup>499</sup> Speaking about the first instance decision in *Carter*, Mr Stephen Walker, Vice President of Dying with Dignity Western Australia, stated:

*But in the end she very clearly comes down on the side of saying that the systems that she has looked at and heard about operate well and*

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495 Mr Marshall Perron, Private Citizen, JSCEOLC Submission 23 at 5-6.

496 Professors White and Willmott in White, McGee and Willmott (2017) 'As Victorian MPs debate assisted dying, it is vital they examine the evidence, not just the rhetoric,' *The Conversation*, 20 September 2017, submitted in Professors Willmott and White, Directors, Australian Centre for Health Law and Research and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, JSCEOLC Submission 560. Similar assertions were also made to the Committee by Mr Neil Francis, JSCEOLC Transcript, 9 April 2018, Session 1 at 10.

497 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 46.

498 2015 SCC 5.

499 Prof Willmott, Director, Australian Centre for Health Law Research, JSCEOLC Transcript, 26 February 2018, Session 2 at 11.

*that there is virtually no abuse, that there is no coercion or imposition upon elderly people or people who are otherwise vulnerable, that safeguards can and do work, and that, as I would read her, nothing is perfect and we need to maintain vigilance. However, overall, despite the myths that go around, she found that the systems in these various jurisdictions do work very well.*<sup>500</sup>

- 3.7. Four important points need to be made here. The first is that there is peer-reviewed evidence of abuse, including peer-reviewed evidence of the abuse of legalised euthanasia here in Australia while the ROTI Act was operational.<sup>501</sup>
- 3.8. Second, in a decision as important as this, to create an exception to the prohibition against the killing of one person by another, the Parliament of Western Australia should take into account all available evidence. Evidence of abuse of the legal limits and the wrongful deaths of individuals in jurisdictions where assisted suicide is legal, whether peer-reviewed or not, should be considered. Whether this evidence should hold any weight will be an assessment made by each Parliamentarian in the decision-making process.
- 3.9. Third, consideration of the decisions made by other jurisdictions who have not legalised assisted suicide should also be made. This Chapter considers those jurisdictions who have rejected the legalisation of assisted suicide, the number of which far outweigh the jurisdictions where assisted suicide is legalised. The *Carter* decision from Canada,<sup>502</sup> so highly relied upon by proponents of assisted suicide, can also be counter-balanced and outweighed with decisions of the House of Lords in the United Kingdom,<sup>503</sup> and the decision of the High Court of Ireland in *Fleming v Ireland & Ors*.<sup>504</sup>
- 3.10. Finally, consideration of the legislation so recently passed in Victoria in the final section of this Chapter, and the criticisms of that legislation by proponents of assisted suicide,

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500 Mr Walker, Vice President, Dying with Dignity (WA), JSCEOLC Transcript, 13 April 2018, Session 5 at 11.

501 See Kissane, Street and Nitschke (1998) 'Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia,' *The Lancet* 352(9134) at 1097-1102 and for international jurisdictions see Kim et al (2016) 'Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011 to 2014,' *JAMA Psychiatry* 73(4) at 362-68; Chambaere et al (2010) 'Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey,' *CMAJ* 182(9) at 895-901; Pereira J (2011) 'Legalising euthanasia or assisted suicide: the illusion of safeguards and controls,' *Current Oncology* 18(2) at 38-45; Golden and Zoanni (2010) 'Killing Us Softly: The Dangers of Legalizing Assisted Suicide,' *Disability and Health Journal* 3(1) at 16-30 and Hendin and Foley (2008) 'Physician-assisted suicide in Oregon: a medical perspective,' *Mich Law Rev* 106 at 1613-40.

502 *Carter v Canada (Attorney General)* 2012 BCSC 886, upheld in *Carter v Canada (Attorney General)* [2015] 1 SCR 331.

503 Report of the Select Committee on Medical Ethics, House of Lords, Vol 1, Session 1993-1994, 1994 London: HMSO.

504 [2013] IESC 19.

## Chapter 3

reveals that extension of eligibility criteria will logically occur following legalisation. The clear and vast evidence from Committee hearings and submissions sustain this conclusion.

### **The Lived Experience in Australia—The Northern Territory**

- 3.11. The WA Chapter of Exit International’s submission to the Committee stated that:

*From the experiences in other jurisdictions, we believe that [protecting patients from possible abuse] can be achieved without subjecting ill people to a protracted bureaucratic process in an already stressful and likely painful situation. In this respect we would also like to mention Australia’s first [voluntary euthanasia] legislation, the Northern Territory’s Rights of the Terminally Ill Act... which had adequate provisions to prevent abuse.<sup>505</sup>*

- 3.12. Evidence was given to the Committee that the law was not broken in the Northern Territory while the ROTI Act was in operation.<sup>506</sup> When asked ‘Do you maintain to this day that your actions were lawful?’ Dr Nitschke answered, ‘Yes, I do. I mean, they were lawful under the Northern Territory Rights of the Terminally Ill Act and all of the four people who went through that arduous selection process demonstrated their eligibility.’<sup>507</sup>
- 3.13. Peer reviewed literature, including a journal article co-authored by Dr Nitschke himself, reveals evidence to the contrary—that deaths occurred that were not lawful under the ROTI Act.<sup>508</sup>
- 3.14. Dr Nitschke, founding member of Exit International, writes in that organisation’s submission that ‘As the only doctor to have lawfully provided voluntary euthanasia to four patients in Australia, I suggest that I have unique insights into how a carefully-worded and construed end of life rights law can operate at a practical level.’<sup>509</sup> He writes, ‘In 1996-97, these safeguards were effective in ensuring that the four of my patients who used the *ROTI Act* in 1996-97 were all terminally ill, of sound mind, had their medical options fully explained, were over 18 years and so on.’<sup>510</sup>
- 3.15. Ironically, in contrast to his own statements and in contrast to Exit International’s submission above, Dr Nitschke gave evidence to the Committee that:

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505 Exit International (WA), JSCEOLC Submission 100 at 2.

506 Mr Neil Francis, Dying for Choice, JSCEOLC Transcript, 9 April 2018, Session 1 at 14-15.

507 Dr Nitschke, Exit International, JSCEOLC Transcript, 13 April 2018, Session 1 at 5-6.

508 Kissane, Street and Nitschke (1998) ‘Seven Deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia,’ *The Lancet* 352(9134) at 1097-1102.

509 Exit International, JSCEOLC Submission 141 at 1.

510 Exit International, JSCEOLC Submission 141 at 2.

*There were problems. Marshall Perron foresaw some of those problems when he said—I remember asking him and talking to him about it before the vote was taken in the territory Parliament. He said he did not want sick people having to jump through hoops—his words. Of course, what we got in that piece of legislation, that Rights of the Terminally Ill Act, was a piece of legislation that made very sick people jump through hoops. When the law passed, I found myself dragging very sick people—in the first case, Bob Dent—from doctor to doctor to get the signatures necessary to demonstrate eligibility to die. The irony of that was not missed on people like Bob Dent who was so sick, yet he said, “I have to qualify to be eligible to die.” I felt cruel having to drag him around to make him satisfy those onerous restrictions of that law. I saw the need for safeguards, but they were particularly difficult ones to comply with.<sup>511</sup>*

#### **The Rights of the Terminally Ill Act 1995 (NT)**

- 3.16. Section 4 of the ROTI Act provided that ‘A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient’s medical practitioner to assist the patient to terminate the patient’s life.’ Section 3 defined a ‘terminal illness’, in relation to a patient, as ‘an illness which, in reasonable medical judgment will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient.’
- 3.17. The ROTI Act further provided that a ‘medical practitioner who receives a request’ may, if certain conditions are met, ‘assist the patient to terminate the patient’s life.’ The conditions to be met included that:

*The medical practitioner is satisfied, on reasonable grounds, that*

- (i) the patient is suffering from an illness that will, in the normal course and without the application of extraordinary measures, result in the death of the patient;*
- (ii) in reasonable medical judgment, there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure; and*
- (iii) any medical treatment reasonably available to the patient is confined to the relief of pain, suffering and/or distress with the*

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511 Dr Nitschke, Exit International, JSCEOLC Transcript 13 April 2018, Session 3 at 2 (emphasis added).

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*object of allowing the patient to die a comfortable death; (s7(1)(b));*

*A second 'medical practitioner who holds prescribed qualifications, or has prescribed experience, in the treatment of the terminal illness from which the patient is suffering' has examined the patient and has confirmed*

*(i) the first medical practitioner's opinion as to the existence and seriousness of the illness;*

*(ii) that the patient is likely to die as a result of the illness; and*

*(iii) the first medical practitioner's prognosis (s7(1)(c)(i) and (iii));*

*'A qualified psychiatrist' has 'confirmed that the patient is not suffering from a treatable clinical depression in respect of the illness' (s7(1)(c)(ii) and (iv)); and*

*The illness is causing the patient severe pain or suffering (s7(1)(d))*

- 3.18. As will be demonstrated below, the circumstances surrounding the deaths of the four patients euthanised under the ROTI Act show that these deaths occurred outside of the abovementioned eligibility prescriptions and safeguards written into the legislation.

### **Lack of access to good palliative care**

- 3.19. First, Dr Nitschke emphasised in evidence to the Committee that one of the safeguards that should be included in assisted suicide law is that 'the person must have exhausted all palliative care options available to them,' a safeguard taken directly from Part 2 of the ROTI Act.<sup>512</sup>
- 3.20. However, palliative care was—in the words of Dr Nitschke himself—an 'embryonic speciality' in the Northern Territory at the time of the ROTI Act.<sup>513</sup> That 'palliative care facilities were underdeveloped in the Northern Territory' was also identified by Kissane, Street and Nitschke in 'Seven Deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia.'<sup>514</sup> In case 3, the patient may have benefited from radiotherapy or strontium but neither of these was available in the Northern Territory.<sup>515</sup> In Case 5, the patient had an obstruction and was clinically

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512 Dr Nitschke, Exit International, JSCEOLC Submission 141 at 1.

513 Dr Nitschke, Exit International, JSCEOLC Transcript, 13 April 2018, Session 1 at 9.

514 Kissane, Street and Nitschke (1998) 'Seven Deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia,' *The Lancet* 352(9134) 1097-102.

515 Ibid at 1099.



jaundiced.<sup>516</sup> Section 7(1)(e) of the ROTI Act required Dr Nitschke as the ‘medical practitioner who receives a request’ to have ‘informed the patient of the nature of the illness and its likely course, and the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures for keeping the patient alive, that might be available to the patient.’ However, Kissane reports that ‘when questioned about options like stenting for obstructive jaundice or the management of bowel obstruction,’ Dr Nitschke ‘acknowledged limited experience, not having been involved in the care for the dying before becoming involved with the *ROTI Act*.’<sup>517</sup> This raises doubts as to whether the patient in this case—who was reported by Dr Nitschke to exhibit ‘indecisiveness’ over a two month period about whether or not to request euthanasia—would still have done so if he had been given better symptomatic relief for the jaundice and obstruction.<sup>518</sup>

### **A patient who was not terminally ill was euthanised**

- 3.21. In Case 4, there was no medical consensus that the patient’s diagnosed medical condition, mycosis fungoides, was a terminal illness: ‘One oncologist gave the patient’s prognosis as nine months, but a dermatologist and a local oncologist judged that she was not terminally ill. Other practitioners declined to give an opinion. In the end an orthopaedic surgeon certified that the *ROTI* provisions for terminal illness had been complied with.’<sup>519</sup>
- 3.22. Professor Quinlan’s legal analysis of the deaths under the ROTI Act is as follows:

*Whilst there were no definitive instances of innocent prisoners being executed, over the 196 year history of capital punishment in Australia, in the brief period in which euthanasia was lawful in the Northern Territory, 2 out of the 7 patients who sought euthanasia were provided with inadequate information of their true medical condition and of their treatment options. Unlike the criminal justice system, with its system of judicial appeals, under the NT Act, if a doctor found that the patient did not meet the criteria for access to euthanasia, the patient (or his or her advisers) could approach an unlimited number of other doctors until one could be found who would give the required opinion. This situation arose during the brief operation of the NT Act in Case 4. When there was no consensus that the patient’s condition satisfied the NT Act’s requirements, among oncologists, the patient made an appeal on national television. An orthopaedic surgeon, who had no expertise in her condition as the NT Act required, provided the certification that the*

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516 Ibid at 1100.

517 Ibid at 1101.

518 Ibid at 1100.

519 Ibid at 1101.

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*patient's condition was terminal and she was euthanised. In Kissane's opinion: 'The voluntariness of her choice for euthanasia was influenced by her not being informed of the availability of effective treatment for depression nor being given the opportunity to have her suffering alleviated.' In Case 5, a patient was jaundiced and suffering from a bowel obstruction but was not advised of the palliative care and medical treatment available. In Kissane's view: 'Given the level of error rate that does occur in medical practice, this experience [of the operation of the NT Act] suggests it would be impossible to safely legislate for doctors to kill.'*<sup>520</sup>

### **Evidence of doctor shopping**

- 3.23. Dr Nitschke confirmed that 'doctor shopping' was involved in the management of Case 4. He gave evidence to the Committee that:

*ultimately because we needed a Territory specialist, and there are not many, we got Stephen Badley, who was an orthopaedic surgeon, who, out of compassion said, "I cannot possibly stand to see this suffering going on any longer. I will sign it and take the heat," and by hell he took the heat.*<sup>521</sup>

- 3.24. Mr Perron also confirmed that the patient's television appeal 'was successful' and a 'specialist who was not a specialist in the relevant disease [signed] off on it because he felt so bad about this woman's plight.'<sup>522</sup> When asked by Hon Nick Goiran in a Committee hearing whether he 'would describe the signing off by the orthopaedic surgeon as a success,' Mr Perron answered:

*it was not necessarily in accordance with the legislation's intent, but no party involved regrets what they did in that circumstance.*<sup>523</sup>

### **Patients with mental illness and undiagnosed demoralisation were euthanised**

- 3.25. From the case histories, it is also apparent that Cases 3 and 4 each had depressive symptoms.
- 3.26. 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

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520 Quinlan M (2016) "Such is Life": Euthanasia and capital punishment in Australia: consistency or contradiction?' *Solidarity: The Journal of Catholic Social Thought and Secular Ethics* 6(1) at 8-9, citing David W. Kissane (2000) 'The Challenge of Informed Consent' *Journal of Pain and Symptom Management* 19 at 473.

521 Dr Nitschke, Exit International, JSCEOLC Transcript, 13 April 2018, Session 1 at 6.

522 Mr Marshall Perron, Private Citizen, JSCEOLC Transcript, 13 April 2018, Session 2 at 9.

523 Ibid.

have used it.’ He had outbursts in which he would ‘yell and scream, as intolerant as hell’ and he ‘wept frequently.’<sup>524</sup>

3.27. 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.’<sup>525</sup>

3.28. In Case 4, the case of non-terminal mycosis fungoides:

*the psychiatrist noted that the patient showed reduced reactivity to her surroundings, lowered mood, hopelessness, resignation about her future, and a desire to die. He judged her depression consistent with her medical condition, adding that side-effects of her antidepressant medication, dozepin, may limit further increase in dose.*<sup>526</sup>

3.29. 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.’<sup>527</sup>

3.30. The patient’s mood appeared to have been ‘normalised’ as a predictable response to her medical condition. Kissane suggests that acceptance that she had an autonomous right to euthanasia (despite the fact that she did not meet the eligibility requirement of a terminal illness) may have prevented this clinician from considering his or her duty under the *Mental Health Act 2007* (Cth) to protect a suicidal patient from endangering herself, the former Act taking precedence over the ROTI Act.<sup>528</sup>

3.31. Further concerns have been raised regarding 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

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524 Kissane, Street and Nitschke (1998) ‘Seven Deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia,’ *The Lancet* 352(9134) 1097-1102 at 1099.

525 Ibid.

526 Ibid at 1100.

527 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 11, citing Kissane, Street and Nitschke (1998) ‘Seven Deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia,’ *The Lancet* 352(9134) 1097-1102.

528 Kissane DW (2000) ‘The Challenge of Informed Consent,’ *Journal of Pain and Symptom Management* 19(6) 473-4 at 473.

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in testimony to a Senate committee, that he also personally paid for this psychiatric consultation and that it in fact took less than 20 minutes.<sup>529</sup>

3.32. Dr Kissane, commenting on the issue of demoralisation, writes:

*Review of these patients' stories highlighted for me the importance of demoralization as a significant mental state influencing the choices these patients made. They described the pointlessness of their lives, a loss of any worthwhile hope and meaning. Their thoughts followed a typical pattern of thinking that appeared to be based on pessimism, sometimes exaggeration of their circumstances, all-or-nothing thinking in which only extremes could be thought about, negative self-labelling and they perceived themselves to be trapped in this predicament. Often socially isolated, their hopelessness led to a desire to die, sometimes as a harbinger of depression, but not always with development of a clinical depressive disorder. It is likely that the mental state of demoralization influenced their judgement, narrowing their perspective of available options and choices. Furthermore, demoralized patients may not make a truly informed decision in giving medical consent.<sup>530</sup>*

3.33. In relation to Case 4, Kissane concludes that:

*The clinical experience observed during the brief life of the ROTI Act could be regarded as an experiment in which the legislation that supported the practice of euthanasia can be examined for its effectiveness. This patient generated a range of ethical concerns regarding the nature and quality of her medical care. Her story demonstrated the inadequacy of provisions of the ROTI Act and suggested that the vulnerable cannot be safely protected by such legislation.<sup>531</sup>*

3.34. It should be noted here that Mr Perron and Dr Nitschke were the only persons whose 'expert' opinions were sought by the Committee on the operation of the ROTI Act. Dr Kissane was also identified to the Committee as an expert in this field,<sup>532</sup> however evidence was not sought from him by the Committee.

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529 P Nitschke, *Hansard*, Senate Standing Committee on Legal and Constitutional Affairs, *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill* 2008, 14 April 2008 at 42, cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 12.

530 Kissane DW (2002) 'Deadly days in Darwin,' in *The Case Against Assisted Suicide*, Foley and Hendin (eds) at 192-209.

531 Kissane DW (2000) 'The Challenge of Informed Consent,' *Journal of Pain and Symptom Management* 19(6), 473-4 at 474.

532 See Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Transcript, 9 March 2018, Session 1 at 10.

**Dr Nitschke—where is he now?**

- 3.35. Apart from being the only medical practitioner to administer euthanasia in Australia under assisted suicide legislation, Dr Nitschke has a long reported history of assisting in the suicides of countless individuals, both in Australia and overseas.
- 3.36. Mrs Judi Taylor advised the ABC that an online forum called Peaceful Pill, run by Exit International (and for which members must pay a fee to access), needlessly facilitated her son's suicide. Mr Lucas Taylor was 26 years old when he committed suicide after following the advice provided to him on the online forum.
- 3.37. Dr Nitschke's response to Mrs Taylor's devastation and criticism was 'If he got the wrong advice she may have had a brain-dead dependent on her hands' and '[t]hat would not be in anyone's interests.'<sup>533</sup> Dr Nitschke has described the deaths of young people like Mr Taylor as a 'casualty' of the need for assisted suicide information to be widely available. As already cited in this Report, Dr Nitschke stated that 'There will be some casualties... but this has to be balanced with the growing pool of older people who feel immense well-being from having access to this information.'<sup>534</sup>
- 3.38. Dr Nitschke is well known for his strongly held belief that assisted suicide should be available to all, regardless of their mental or physical health:

*I do not believe that telling people that they have a right to life while denying them the means, manner, or information necessary for them to give this life away has any ethical consistency... And someone needs to provide this knowledge, training, or recourse necessary to anyone who wants it, including the depressed, the elderly bereaved, the troubled teen.*<sup>535</sup>

- 3.39. In September 2014, it was reported that Dr Nitschke was being investigated by police in every Australian state over his possible role in nearly 20 deaths in the previous three years, all of them apparently suicides. One investigation by Victoria Police concerned the death of a 55-year-old Geelong man who allegedly killed himself using a self-administered kit bought through a company affiliated with Exit International. All of the

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533 Dr Nitschke, quoted in Stephanie Chalkley-Rhoden, 'Exit International forum coached young man to his death, mother claims,' *ABC News*, 26 July 2014.

534 Julia Medew 'Young people gain access to euthanasia drug' *Sydney Morning Herald*, 15 February 2010 <<https://www.smh.com.au/lifestyle/health-and-wellness/young-people-gain-access-to-euthanasia-drug-20100215-nzon.html>>

535 Philip Nitschke and Fiona Stewart (2005) *Killing Me Softly: Voluntary Euthanasia and the Road to the Peaceful Pill* at 312.

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deaths being investigated involved the use of the two suicide methods promoted by Dr Nitschke—Nembutal or a nitrogen inhalant device.<sup>536</sup>

- 3.40. Dr Nitschke has been associated with many high-profile deaths, including that of 70-year-old Nancy Crick (as previously mentioned in Chapter 2 in the section entitled *Error in diagnosis*), whose autopsy revealed that she did not have cancer, a fact which Nitschke deemed ‘irrelevant’;<sup>537</sup> Syd and Marjorie Croft, a healthy couple in their late 80s;<sup>538</sup> 79-year-old Lisette Nigot in Perth who was neither ill nor in pain,<sup>539</sup> and Alzheimer’s sufferer Graeme Wylie, whose family friend (and euthanasia supporter) had obtained Nembutal to be administered to him and which was finally administered to him by his wife. The wife and friend involved claimed that Mr Wylie had wanted to end his own life, but a jury found that he lacked the capacity to decide due to his Alzheimer’s disease.<sup>540</sup> Petrified of going to jail, the family friend who obtained the Nembutal, took her life with the same drug she illegally obtained for Mr Wylie.<sup>541</sup>
- 3.41. Dr Nitschke was suspended by the Medical Board of Australia after investigation into his involvement in the death of Perth man Nigel Brayley. Mr Brayley, 45, died in May 2014 after contacting Dr Nitschke and taking the euthanasia drug Nembutal. Mr Brayley was implicated in the deaths of two of his partners and feared being charged with his wife’s murder.<sup>542</sup> Though he denied that he had breached his professional obligations by assisting in Mr Brayley’s suicide, the Medical Board suspended Dr Nitschke, citing that he presented ‘a serious risk to public health and safety.’<sup>543</sup> Dr Nitschke’s response was

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536 J Davies, ‘Euthanasia campaigner Nitschke investigated over more deaths,’ *The Age*, 28 September 2014 <<http://www.smh.com.au/national/euthanasia-campaigner-nitschke-investigated-over-more-deaths-20140927-10msng.html>>

537 A Bolt, ‘At last, we wake up to Dr Death, Philip Nitschke,’ *Herald Sun*, 6 July 2014 <<https://www.heraldsun.com.au/news/opinion/andrew-bolt/at-last-we-wake-up-to-dr-death-philip-nitschke/news-story/b106a0996e5132af63dcfa3233d156dc>>

538 ‘Healthy choosing premature death, says Nitschke,’ *The Age*, 16 December 2002 <<https://www.theage.com.au/national/healthy-choosing-premature-death-says-nitschke-20021216-gduxwr.html>>

539 ‘Healthy woman thanks Dr Nitschke, then kills herself,’ *The Sunday Morning Herald*, 26 November 2002 <<https://www.smh.com.au/national/healthy-woman-thanks-dr-nitschke-then-kills-herself-20021126-gdfvde.html>>

540 Angus Hohenboken ‘Manslaughter ruling over euthanasia,’ *The Australian*, 20 June 2008 <<https://www.theaustralian.com.au/news/nation/manslaughter-ruling-over-euthanasia/news-story/58ea4f84aa3bdfbd9e5808cac973f495?sv=c1d2259110d4d688375edce43624700d>>

541 Kim Arlington, ‘Euthanasia advocate Caren Jennings “bullied” in trial’ *The Daily Telegraph*, 21 September 2008 <<https://www.dailytelegraph.com.au/news/nsw/suicide-to-avoid-dying-in-jail/news-story/73d64c27e51a2070a93c4fae258ee4ea?sv=9a5853d7aff43bd0061e2a1ea95c7de3>>

542 ‘Philip Nitschke denies he “went too far” helping depressed Nigel Brayley die,’ *news.com.au* 4 July 2014 <<https://www.news.com.au/national/western-australia/philip-nitschke-denies-he-went-too-far-helping-depressed-nigel-brayley-die/news-story/1aa59a8c9ce52838f294146f20bcfb0?>>

543 Stephanie Chalkley-Rhoden, ‘Exit International forum coached young man to his death, mother claims,’ *ABC News*, 26 July 2014 <<http://www.abc.net.au/news/2014-07-25/euthanasia-forum-coached-young-man-into-taking-his-life-mother/5623408>>

'That's about the most ludicrous thing they've said, that... telling me I'm no longer a practising doctor is going to somehow or other change things.'<sup>544</sup>

- 3.42. Dr Nitschke has developed suicide machines,<sup>545</sup> advised on recipes for homemade pills to assist in suicide,<sup>546</sup> and has developed a testing kit to allow people who have purchased Nembutal to test its potency.<sup>547</sup> In 2006, Exit International published the *Peaceful Pill Handbook*, co-authored by Dr Nitschke. The *Peaceful Pill Handbook* enables readers to compare for themselves the benefits of various options such as Nembutal, Helium and the Exit Bag, prescription drugs, carbon monoxide, cyanide and the DIY peaceful pill.<sup>548</sup> Although the *Peaceful Pill Handbook* was banned by the Australian Federal Government in February 2007, Exit International conduct workshops on how to bypass the Australian Government's internet filter to order and download it, and continue to revise and sell new editions at its website, on Amazon and for Kindle.<sup>549</sup>
- 3.43. More recently, in commenting on the work of the Last Wish Cooperative in the Netherlands, who claim to distribute a lethal powder to those who wish to commit suicide, Dr Nitschke states in an Exit International Media Release:

*With the wide, legal availability of this new drug, no one will bother with a restrictive euthanasia legislation that requires people close to death to obtain permission from a doctor to die. When the time is right, people craving a peaceful death, will simply take this new drug. No one will bother with the legislative safeguards in new proposed legislation, when this product becomes available.*<sup>550</sup>

- 3.44. Dr Nitschke continues his activities promoting suicide, only in April this year showcasing a 'suicide machine' at an Amsterdam funeral fair, which Dr Nitschke hopes will one day be available as a 3D-printable device.<sup>551</sup>

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544 'Euthanasia advocate Philip Nitschke suspended by the Medical Board of Australia' *ABC News*, 23 July 2014 <<http://www.abc.net.au/news/2014-07-24/euthanasia-advocate-philip-nitschke-suspended-by-medical-board/5615268>>

545 'Nitschke suicide device out' *Sydney Morning Herald*, 3 December 2002

<<https://www.smh.com.au/national/nitschke-suicide-device-out-20021203-gdfwqf.html>>

546 Philip Nitschke and Fiona Stewart (2005) *Killing Me Softly: Voluntary Euthanasia and the Road to the Peaceful Pill*.

547 'Nitschke unveils new euthanasia aid' *ABC News*, 18 June 2009

<<http://www.abc.net.au/news/2009-06-18/nitschke-unveils-new-euthanasia-aid/1324714>>

548 'The Peacefull Pill handbook' <<https://www.peacefulpillhandbook.com/about-the-handbook/>>

549 Steele and Worswick (2013) 'Destination death: A review of Australian legal regulation around international travel to end life,' *JLM* 21, 415.

550 Exit International Media Release, 'Dutch Euthanasia Drug Breakthrough De-rails WA Legislative Change,' dated 2 September 2017 <<https://exitinternational.net/media/MRWAAug17.pdf>>

551 'Nitschke's 'suicide machine' draws crowds at Amsterdam funeral fair,' *The Guardian*, 15 April 2018; Caroline Overington, 'Philip Nitschke invents suicide capsule with 3D printer,' *The Australian*, 24 November 2017 <<https://www.theaustralian.com.au/news/health-science/philip->

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- 3.45. Dr Nitschke now resides in the Netherlands and remains active in Exit International, and has been affiliated with the Last Wish Cooperative, an organisation that supports access to suicide without the constraints of the participation of the medical profession. This directly contradicts the evidence given to the Committee by Mr Luley of Dignitas (Switzerland), who suggests that ‘...if you want to get rid of Dr Nitschke’s Exit International, you must do what he is doing. People only turn to organisations like Dignitas or Exit International and Philip Nitschke because they are not met at eye level with their wishes, with their fears, with their needs.’<sup>552</sup> The Netherlands has one of the most widely framed euthanasia laws in the world, and that is where Dr Nitschke has chosen to reside and continues his work assisting the suicides of anyone who seeks it. This was acknowledged by Mr Denton, who gave evidence to the Committee that

*I think regardless of what law you write—this exists even in the Netherlands, which has had the longest and deepest conversation about this of any society on earth—their remains societies, like Dr Nitschke’s Exit in Australia, an organisation about which I have mixed feelings, that supply the means to people, or supply the advice to people to get the means, for people such as you have described, to end their life as they choose on their own terms.*<sup>553</sup>

- 3.46. The question for the Western Australian Parliament to answer is not a complicated one: Should Dr Nitschke be given a licence to ‘set up shop’ in WA? If the answer is yes, then lawmakers should press ahead with the legalisation of assisted suicide. If the answer is no, then the collective energies and efforts of lawmakers would be better directed to ensuring that every Western Australian in need has access to specialist palliative care, including dignity therapy and consultation-liaison psychiatry.

### Finding 70

When assisted suicide was legal in the Northern Territory one patient, diagnosed with mycosis fungoides and receiving treatment for depression, was euthanised on the certification of an orthopaedic surgeon with no expertise in the condition, notwithstanding that a dermatologist and a local oncologist had assessed that the patient was not terminally ill.

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[nitschke-invents-suicide-capsule-with-3d-printer/news-story/318561693f3a6eee1e10069df83a3839?login=1](https://www.jseolc.gov.au/news-story/318561693f3a6eee1e10069df83a3839?login=1)

552 Mr Luley, Board member, Dignitas, Switzerland, JSCEOLC Transcript, 8 March 2018, Session 5 at 4.

553 Mr Denton, Go Gentle Australia, JSCEOLC Transcript, 13 April 2018, Session 6 at 11.



**Finding 71**

When assisted suicide was legal in the Northern Territory one patient was euthanised even though he was jaundiced and suffering from a bowel obstruction and not advised of the palliative care and medical treatment available. The psychiatric certification in that case consisted of a 20-minute consultation paid for by Dr Philip Nitschke on the day the assisted suicide was scheduled.

**Finding 72**

Doctor shopping took place when assisted suicide was legal in the Northern Territory.

**Finding 73**

When assisted suicide was legal in the Northern Territory one patient, who had received counselling and anti-depressant medication for several years, was euthanised after a psychiatrist from another State certified that no treatable clinical depression was present, notwithstanding that 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 assisted suicide.

**Finding 74**

The clinical experience observed during the period when assisted suicide was legal in the Northern Territory demonstrates the inadequacies of safeguards and this experience alone ought to militate against legalisation in Western Australia.

**Recommendation 13**

The Government and the Parliament of Western Australia should rule out introducing any assisted suicide regime based on the Northern Territory experience.

**The European Experience—The Netherlands**

- 3.47. Although it is illegal under Dutch criminal law to assist in suicide or to terminate life upon request, since 1973 Dutch courts have recognised a defence of 'necessity' which permits a doctor to avoid liability by pointing to his or her duty 'to reduce suffering or to respect the personality [autonomy] of the patient.'<sup>554</sup> Magnusson notes that:

*The requirements for the necessity defence have undergone subtle elaboration over the past three decades. In November 2000 the defence was, for the first time, given an explicit statutory basis, following the approval of amendments to the Dutch Penal Code by the Lower House of the Dutch Parliament. These amendments were passed by the Upper House in April 2001. To avoid liability under the Penal Code, doctors will be required to satisfy the 'due care' requirements set out in the*

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554 Magnusson RS (2002) *Angels of death: exploring the euthanasia underground* at 64.

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*Termination of Life on Request and Assisted Suicide (Review Procedures) Act. In addition, the doctor must report the death to the municipal coroner as required under Dutch burial legislation.*

*Under the due care requirements, it is not necessary for the patient to be suffering physical pain: unbearable mental anguish is sufficient. Similarly, there is no requirement for the patient to be in the terminal phase of an illness, or indeed to be suffering from any (physical) disease at all. A physical disability, or a condition of ‘untreatable misery’, will suffice. Where the patient’s suffering is non-somatic in origin, the new legislation does not explicitly require the treating doctor to arrange for psychiatric review, although this seems implicit in the requirements that the independent doctor must certify that the patient’s condition is hopeless and without prospect of improvement. More generally, however, ‘due care’ does not require depression, or any psychiatric illness, to be excluded.<sup>555</sup>*

- 3.48. Professor Willmott gave evidence to the Committee that:

*Our understanding is that the Dutch law has not altered since it was first enacted. When it was first enacted, minors, in some circumstances, were entitled to access assistance to die, but that has not been altered in the Netherlands... I understand that there is currently some review in the Netherlands about whether or not they should be reforming the Dutch law around euthanasia, but, as yet, it has not been changed.<sup>556</sup>*

- 3.49. Professor Willmott’s understanding of the law is incorrect. Until 2001, the Netherlands allowed only adults access to euthanasia or physician-assisted suicide. However, in 2001 the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* was passed to allow for children aged 12–16 years to be euthanised if consent is provided by their parents, even though this age group is generally not presumed to have capacity. The law even allows physicians to proceed with euthanasia if there is disagreement between the parents. By 2005, the Groningen protocol, which allows euthanasia of newborns and younger children who are expected to have ‘no hope of a good quality of life,’ was implemented.<sup>557</sup>
- 3.50. The Groningen protocol was developed by a committee of physicians and lawyers at the University Medical Centre Groningen in order to assist with the decision making process

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555 Ibid at 64-65.

556 Prof Willmott, Director, Australian Centre for Health Law Research, JSCEOLC Transcript, 26 February 2018, Session 2 at 11.

557 Pereira J (2011) ‘Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls,’ *Current Oncology* 18(2) 38-45 at 41.

when considering actively ending the life of a newborn, by providing the information required to assess the situation within a legal and medical framework.<sup>558</sup>

- 3.51. Under the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001*, euthanasia technically remains illegal for patients under the age of 12. The Groningen protocol does not give physicians unassailable legal protection and no black letter law exists in this area. However, courts have so far protected physicians from prosecution so long as they act in accordance with the protocol.<sup>559</sup>
- 3.52. What is important to note is that the active termination of the life of newborns in the Netherlands was occurring prior to the introduction of the Groningen protocol, and without prosecution. A 2005 review study of 22 reported cases of the active ending of the life of a newborn between 1997 and 2004 (prior to the drafting of the Groningen protocol) found that all of these cases had been performed in accordance with ‘good practice’ and confirmed that none of these cases were prosecuted.<sup>560</sup> Unreported cases of the active ending of life of a newborn during this period were not considered in the study.
- 3.53. As Dr Herbert Hendin explained in congressional testimony, Dutch policies have gradually expanded from assisted suicide to euthanasia for the terminally ill to euthanasia for the chronically ill; to euthanasia for ‘psychological distress;’ and from voluntary euthanasia to involuntary euthanasia, which ‘has been justified as necessitated by the need to make decisions for patients not [medically] competent to choose for themselves.’<sup>561</sup> The idea of allowing death to be a solution to the problem of suffering was first accepted by the courts in 1973, though initially only in very special, limited cases. Stahle explains that this ‘threshold event’ set in motion a development where this idea was expanded further through a series of court rulings and prosecution concessions. The law ‘was adapted to fit the practice instead of vice versa.’<sup>562</sup>

#### **Extension of the law to include euthanasia for psychiatric illness**

- 3.54. Prior to 1994, the Dutch Supreme Court had recognised a defence of ‘necessity’ under narrowly defined circumstances to a charge of performing euthanasia. In the 1994

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558 Verhagen and Sauer (2005) ‘The Groningen protocol – euthanasia in severely ill newborns,’ *N Engl J Med* 352(10) 959-62.

559 Lindemann and Verkerk (2008) ‘Ending the Life of a Newborn: the Groningen Protocol,’ *The Hastings Centre Report* 38(1) at 42-51.

560 Verhagen, Brouwer and Sauer (2005) ‘Deliberate termination of life in newborns in the Netherlands; review of all 22 reported cases between 1997 and 2004,’ *Ned Tijdschr Geneesk* 149(4) at 183-8.

561 Hendin H, *Suicide, Assisted Suicide and Euthanasia: Lessons From the Dutch Experience: Hearings Before the Subcommittee on the Constitution of the House Comm. on the Judiciary*, 104th Congress, 2nd Session, 29 April 1996, cited in Golden and Zoanni (2010) ‘Killing Us Softly: The Dangers of Legalizing Assisted Suicide,’ *Disability and Health Journal* 3(1) 16-30 at 27.

562 Stahle F (2017) ‘Moral disengagement – Mechanisms Propelling the Euthanasia/PAS Movement,’ *Journal of Ethics in Mental Health* 10 at 12.

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*Chabot* case,<sup>563</sup> the Court expanded the defence to include assistance of patients whose suffering was not of somatic origin (somatic relating to the physical body, as distinct from the mind).

3.55. JT Smies summarises the *Chabot* case as follows

*Dr. Boudewijn Chabot was a psychiatrist who supplied lethal drugs to a patient who had recently experienced a series of traumatic events that had left her with no desire to live. Although offered treatment for her condition, the patient refused. The Court began by affirming its earlier holdings that euthanasia and assisted suicide can be justified if: the defendant acted in a situation of necessity, that is to say... that confronted with a choice between mutually conflicting duties, he chose to perform the one of greater weight. In particular, a doctor may be in a situation of necessity if he has to choose between the duty to preserve life and the duty as a doctor to do everything possible to relieve the unbearable and hopeless suffering of a patient committed to his care. The prosecution argued that the defence of justification should not be available to doctors who assist with suicides in cases where the suffering is non-somatic and the patient is not in the 'terminal phase.' The Supreme Court rejected this contention, and held that in such cases the justification can be rooted in the autonomy of the patient herself. The Court noted that, 'the wish to die of a person whose suffering is psychic can be based on an autonomous judgment.'*<sup>564</sup>

3.56. Euthanasia is now legally permitted in the Netherlands for dementia patients and for persons with depression or other mental health issues in the complete absence of any physical illness or suffering.<sup>565</sup> Euthanasia was performed in 2015 for personality disorder with post-traumatic stress disorder and self-mutilation, and obsessive compulsive disorder.<sup>566</sup>

3.57. The rate of euthanasia for psychiatric illness in the Netherlands has also been increasing. A 1997 study estimated that the annual number of cases was between 2 and 5, while in 2013 there were 42 reported cases.<sup>567</sup> In 2016 there were 60 notifications of euthanasia

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563 *Office of Public Prosecutions v Chabot*, Nederlandse Jurisprudentie 1994, nr 656; Tijdschrift voor Gezondheidsrecht 1994-96, nr 74.

564 Smies JT (2003-2004) 'The legalisation of euthanasia in the Netherlands,' *Gonzaga Journal of International Law* 7 at 19-20, quoted by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 7.

565 Regional Euthanasia Review Committees, *Annual report 2010* at 10, 13 and 22-23, cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 7.

566 Regionale Toetsingscommissies Euthanasie, Jaarverslag 2015 at 50-52, cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 7.

567 Kim et al (2016) 'Euthanasia and Assisted Suicide of Patients With Psychiatric Disorders in the Netherlands 2011 to 2014,' *JAMA Psychiatry* 73(4) 362-368 at 363.

or assisted suicide involving patients with psychiatric disorders (more than four times the cases in 2012 (14 cases)), and 141 notifications involving dementia (more than three times the notifications involving dementia in 2012 (42 cases)). These cases were in the absence of any other condition justifying euthanasia.<sup>568</sup>

- 3.58. A study by Kim et al found that persons receiving euthanasia or physician-assisted suicide in the Netherlands for psychiatric disorders were mostly women with complex and chronic psychiatric, medical and psychosocial histories, and disagreements about patient eligibility among physicians was not unusual. Euthanasia and physician-assisted suicide proceeded with the disagreements unresolved for most cases.<sup>569</sup>

### **The rise of private organisations involved in offering euthanasia to patients deemed ineligible by their physician**

- 3.59. Kim et al note the emergence in 2012 of the ‘End-of-Life Clinic’ (Levenseindekliniek) in Netherlands, who provide euthanasia and physician-assisted suicide (EAS) to patients whose own physician has declined to perform EAS. The End-of-Life Clinic consists of mobile teams made up of a physician and a nurse funded by Right to Die NL (Nederlandse Vereniging voor een Vrijwillig Levenseinde, the Dutch association for a voluntary end of life).<sup>570</sup>
- 3.60. The End-of-Life Clinic are increasingly involved in the assisted suicide of persons suffering from psychiatric illness. End-of-Life Clinic cases represented 1 of 12 cases in 2012, 6 of 32 cases in 2013, and 8 of 16 cases in 2014.<sup>571</sup> By 2016, more than half (37) of the 60 cases of euthanasia for psychiatric disorders in 2016 were carried out by doctors from the End-of-Life Clinic.<sup>572</sup>

### **The ‘tired of life’ argument currently underway**

- 3.61. Paul Appelbaum, Chair of the World Psychiatric Association’s ethics committee, criticises the risk that euthanasia for psychiatric illness presents, ‘inducing hopelessness among other individuals with similar conditions and removing pressure for an improvement in psychiatric and social services.’<sup>573</sup>
- 3.62. Theo Boer, ethicist and former supporter of euthanasia in the Netherlands, gave evidence to the AMA(WA) in their recent Symposium on end of life choices that suicide

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568 Regionale Toetsingscommissies Euthanasie, Jaarverslag 2016 at 12, cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 7.

569 Kim et al (2016) ‘Euthanasia and Assisted Suicide of Patients With Psychiatric Disorders in the Netherlands 2011 to 2014,’ *JAMA Psychiatry* 73(4) 362-368 at 365.

570 Ibid at 363.

571 Ibid at 365.

572 Regionale Toetsingscommissies Euthanasie, Jaarverslag 2016 at 15, cited in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 7.

573 Paul S Appelbaum (2016) ‘Physician-Assisted Death for Patients With Mental Disorders – Reasons for Concern,’ *JAMA Psychiatry* 73(4) 325-326.

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has been normalised in the Netherlands, and as such, there has been an increase in the suicide rate in that country when compared with the similar jurisdiction of Germany, where euthanasia is not legalised.<sup>574</sup>

- 3.63. In October 2016, the Minister for Health and Minister for Justice in the Netherlands began promoting that all elderly people who are ‘tired of living’ should be offered medical assistance to die. In support of the proposal, Health Minister Edith Schipper outlined how beneficial it is for many elderly people to die, as compared to continuing to live.<sup>575</sup> Legislators in the Netherlands are proposing a ‘Completed Life Bill’ that would allow anybody age 75 years or older to be euthanised, even if they are healthy.<sup>576</sup>
- 3.64. Dr Nitschke gave evidence to the Committee that this is logically where the debate will go in Western Australia, and welcomes the opportunity for such debate:

*I want to see a debate held about a ‘tired of life’ argument such as we are seeing here in the Netherlands. Should every person over a certain age be issued with those drugs? That is where the debate will go. I am predicting that. It will happen even in Western Australia and other Australian states, because that is where the debate around the world is heading.<sup>577</sup>*

### **An erosion of medical standards in the care of the terminally ill**

- 3.65. Government-sanctioned studies suggest an erosion of medical standards in the care of terminally ill patients in the Netherlands where 50 per cent of Dutch cases of assisted suicide and euthanasia are not reported, more than 50 per cent of Dutch physicians feel free to suggest euthanasia to their patients, and 25 per cent of these physicians admit to ending patients’ lives without their consent (more than 1000 people each year).<sup>578</sup>
- 3.66. Lord McColl of Dulwich, in evidence to the House of Lords, stated:

*My first experience of the Dutch euthanasia law occurred when I visited the Netherlands as a member of the Select Committee on Medical*

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574 Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 18 May 2018, Session 1 at 3-4 and at 8.

575 Stahle F (2017) ‘Moral disengagement – Mechanisms Propelling the Euthanasia/PAS Movement,’ *Journal of Ethics in Mental Health* 10 at 4.

576 Dwight Randal, President, Coalition for the Defence of Human Life, Presentation to the Select Committee on End of Life Choices, included in JSCEOLC Response to Questions on Notice, 17 April 2018 at 5.

577 Dr Nitschke, Exit International, JSCEOLC Transcript, 13 April 2018, Session 1 at 8.

578 The Committee to Study the Medical Practice Concerning Euthanasia (1991) *Medical decisions about the end of life*, The Hague, Vols 1 and 2, 1 September 1991; and Hendin, H (2004) ‘Commentary: the case against physician-assisted suicide: for the right to end-of-life care’ *Psychiatric Times* 21(2) <<http://www.psychiatrictimes.com/geriatric-psychiatry/commentary-case-against-physician-assisted-suicide-right-end-life-care>> cited in Golden and Zoanni (2010) ‘Killing Us Softly: The Dangers of Legalizing Assisted Suicide,’ *Disability and Health Journal* 3(1) 16-30 at 27.

*Ethics, chaired by the noble Lord, Lord Walton of Detchant. The Dutch doctors told us: "We agonised over our first case of euthanasia all day, but the second case was much easier and the third was a piece of cake." We found that rather chilling.*<sup>579</sup>

- 3.67. Boudewijn Chabot, the psycho-geriatrician and prominent euthanasia supporter involved in the *Chabot* case in 1994 which saw Dutch law extended to allow euthanasia for psychiatric illness, said very recently that things are 'getting out of hand... look at the rapid increase... The financial gutting of the healthcare sector has particularly harmed the quality of life of these types of patients. It's logical to conclude that euthanasia is going to skyrocket.'<sup>580</sup>
- 3.68. Of physicians in the Netherlands, 15 per cent have expressed concern that economic pressures may prompt them to consider euthanasia for some of their patients, with a case already cited of a dying patient who was euthanised to free a hospital bed.<sup>581</sup>

#### **The Regional Euthanasia Review Committees and their permissive findings**

- 3.69. Not only is the continual extension of the law in the Netherlands of concern, there has also been an increasing tolerance toward transgressions of the law with almost all decisions by the Regional Euthanasia Review Committees (RTE) finding in favour of the medical practitioner that due care criteria have been met, even in the most grievous of cases. These cases reveal an increasing tolerance toward transgressions of the law and a change in societal values toward assisted suicide after legalisation.
- 3.70. In the first four years after the euthanasia law came into effect in the Netherlands, 16 cases (0.21 per cent of all notified cases) were sent to the judicial authorities, few were investigated, and none were prosecuted. In one case, a counsellor who provided advice to a non-terminally ill person on how to suicide was acquitted.<sup>582</sup>
- 3.71. Only one of 110 psychiatric EAS cases reported to the RTE during 2011 to 2014 did not meet the due care criteria. Four of the 5306 EAS cases (0.1 per cent) in 2014 were judged as not meeting the due care criteria.<sup>583</sup> Such a statistic could be cited as evidence of the success of the Dutch laws and the adherence of medical practitioners to due care criteria.

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579 Lord McColl of Dulwich, *Hansard*, House of Lords, 6 May 1998, Vol 589 cc707-26 (emphasis added).

580 Boudewijn Chabot quoted by Dwight Randal, President, Coalition for the Defence of Human Life, Presentation to the Select Committee on End of Life Choices, included in JSCEOLC Response to Questions on Notice, 17 April 2018 at 5.

581 George, Finlay and Jeffrey (2005) 'Legalised euthanasia will violate the rights of vulnerable patients' *BMJ* 331, 684-5, referenced in Pereira J (2011) 'Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls,' *Current Oncology* 18(2), 38-45 at 42.

582 Pereira J (2011) 'Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls,' *Current Oncology* 18(2), 38-45 at 40.

583 Kim et al (2016) 'Euthanasia and Assisted Suicide of Patients With Psychiatric Disorders in the Netherlands 2011 to 2014' *JAMA Psychiatry* 73(4) 362-368 at 367.

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However, the retrospective oversight system in the Netherlands generally defers to the judgments of the physicians who perform and report euthanasia and physician-assisted suicide.<sup>584</sup> Further consideration of the cases involved reveals that the review process favours medical practitioners and like the Dutch laws themselves, the approach of the RTE has broadened the scope of acceptable practice on a case by case basis.

- 3.72. Among all 110 psychiatric cases reported to the RTE, the RTE found that the due care criteria were not met in only one patient, a woman (case 2014-01) in her 80s with chronic depression who sought help from the End-of-Life Clinic. The clinic physician met with her twice (the first time was 3 weeks before her death), and the patient was not alone on both occasions, with family members present. The physician was not a psychiatrist, did not consult psychiatrists, was unaware of the Dutch Psychiatric Association Guidelines, and yet 'had not a single doubt' about the patient's prognosis. The consultant in the case, a general practitioner, agreed with the physician that all due care criteria were met.<sup>585</sup>
- 3.73. In another case, the RTE was critical yet judged that the physician acted with due care. The patient (case 2013-27) had attempted suicide, which led to a broken thigh. The patient refused all treatments and requested EAS. The RTE was 'puzzled' by the fact that this physician 'complied with the patient's [EAS] wish almost at once' and criticised the physician for prematurely opting for the EAS evaluation because the RTE could 'not exclude the possibility that the patient might yet have accepted treatment.' However, the RTE ultimately decided that the case met the due care criteria 'at the moment' the euthanasia was implemented.<sup>586</sup>
- 3.74. What of those cases where a finding against the medical practitioner was made, where it was held that due care criteria had not been met? In case 15 of the *2011 Annual Report*, the RTE 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 euthanised her, as she is already dead by euthanasia.<sup>587</sup> The same lack of remedy applies to the two cases of people with dementia who were euthanised in 2012 in relation to which the Review Committees found 'not to have been handled with due care.'<sup>588</sup> In Case 2015-01 the RTE found a lack of due care before euthanasia was carried

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584 Ibid.

585 Ibid at 366.

586 Ibid.

587 Regional Euthanasia Review Committees, *Annual report 2011* at 17 cited in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 26.

588 Regional Euthanasia Review Committees, *Annual report 2012* at 13 cited in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 26.



out on a woman with a history of stomach pains from an undiagnosed cause, who was reluctant to be examined by a geriatrician. No further action was taken on this case.<sup>589</sup>

- 3.75. Criminal investigations into five cases of euthanasia in the Netherlands have been launched since March 2018, after a sharp rise in the number of physician-assisted deaths.<sup>590</sup> Two deaths being examined by the prosecutor in the Noord-Holland province involve a doctor employed by the End-of-Life Clinic. It is claimed that a 67-year-old woman, who lacked the capacity to express her own will because of Alzheimer's, was euthanised in May 2017 despite the physician being unable to ascertain whether the request for death was voluntary and deliberate. In a second case, an 84-year-old woman was euthanised in June 2017 after claiming her life was 'hopeless' because of several physical illnesses. It has been suggested that this was not sufficiently proven to be case.
- 3.76. The public prosecutor in Oost-Nederland is also investigating the euthanasia of a 72-year-old woman in April 2017 who had metastasised cancer but lapsed into a coma, which circumstance the RTE determined left the physician unable to ascertain that the decision for euthanasia was voluntary and well-considered. In the fourth case, which is being investigated in The Hague, a euthanasia request from an 84-year-old woman was granted in February 2017 after the patient complained that her freedom of movement had been 'very much restricted' by pulmonary emphysema. It has been claimed the physician concluded too easily that the suffering of the patient was hopeless.<sup>591</sup>
- 3.77. The fifth case involves the euthanasia of an elderly woman suffering from Alzheimer's disease who was physically restrained by family while euthanasia was administered by a physician. In Case 2016-85 the RTE found that the doctor involved 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 'whenever I think the time is right.' Later, the patient said several times in response to being asked if she wanted to die: 'But not just now, it's not so bad yet!' At the time the doctor euthanised the patient she was unable to voluntarily request euthanasia as she had lost capacity. The doctor gave evidence to the RTE that she was fulfilling a written request the patient had made for euthanasia years before and that since the patient was not competent, nothing the woman said during her euthanasia procedure was relevant. The

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589 Regionale Toetsingscommissies Euthanasie, Jaarverslag 2015 at 28-31, cited in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 27.

590 Daniel Boffey, 'Dutch prosecutors to investigate euthanasia cases after sharp rise,' *The Guardian*, 12 March 2018; Maria Cheng, 'Dutch probe 'appalling' euthanasia of dementia patient,' *Medical Xpress*, 20 April 2018.

591 Daniel Boffey, 'Dutch prosecutors to investigate euthanasia cases after sharp rise,' *The Guardian*, 12 March 2018.

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RTE found that even if the patient had said at that moment ‘I don’t want to die,’ the doctor would have continued.<sup>592</sup>

- 3.78. In Case 2016-85, the doctor had put medication into the patient’s coffee to reduce her consciousness deliberately so as to avoid her resisting being given the euthanasia drugs. Nonetheless she struggled against the administration of an intravenous lethal injection and was physically restrained by family members while the doctor completed the administration of the lethal drugs. The RTE found that given the clear signs that the patient was struggling to protest her death, the doctor should have stopped. On the morning of the euthanasia, when her family was present, the patient was even making plans to go out to eat with them.<sup>593</sup>
- 3.79. The outcome in these five cases remains to be seen. Whatever the outcome it will be of no comfort to the respective patients.

### ‘Don’t go there’

- 3.80. In reviewing the Dutch experience, Dr Khorshid of the AMA(WA) gave the following evidence to the Committee:

*probably the most poignant individual comment from the whole symposium was that of Theo Boer. When Dr Noonan asked him what was his advice to AMA WA in this debate, he said that if he looked in the bottom of his heart, he would say, “Don’t go there.” This is the position of somebody who has been a supporter and who is an ethicist and has thought a lot about it and had a lot of experience, but he has seen, I guess, a liberal model and the damage that has done to his society. That is not necessarily a widely held view in the Netherlands. I know there would be a lot of very strong supporters of what happens in the Netherlands. But someone who has thought about it deeply and been deeply involved has said to us, be very, very careful, and I think we should heed that message.<sup>594</sup>*

- 3.81. The evidence considered in this section on the Dutch experience, from government, peer-reviewed and wider sources, should give the Western Australian Parliament pause before considering the legalisation of assisted suicide in Australia. Proponents suggest that there is no evidence of abuse in this jurisdiction, but that is plainly false. This

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592 Regionale Toetsingscommissies Euthanasie, Jaarverslag 2016, p. 54-58 <<https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2016/april/12/jaarverslag-2016/RTEjv2016.pdf>>; Regional Euthanasia Review Committees Annual Report 2016 [https://english.euthanasiecommissie.nl/binaries/euthanasiecommissie-en/documents/publications/annual-reports/2002/annual-reports/annual-reports/RTE\\_annual\\_report\\_2016.pdf](https://english.euthanasiecommissie.nl/binaries/euthanasiecommissie-en/documents/publications/annual-reports/2002/annual-reports/annual-reports/RTE_annual_report_2016.pdf)>

593 Ibid.

594 Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 18 May 2018, Session 1 at 8.

evidence shows that we should heed Professor Theo Boer's expert advice and reject the legalisation of assisted suicide in this State.

**Finding 75**

In 1973, Dutch courts interpreted a defence of necessity to permit a doctor to avoid liability for euthanasia and assisted suicide by pointing to his or her duty to reduce suffering or to respect the autonomy of the patient.

**Finding 76**

After 1973, Dutch courts elaborated on their interpretation of a doctor's defence of necessity, incrementally increasing the scope of practice of euthanasia in the Netherlands, including for psychiatric illness, albeit restricted to adults only.

**Finding 77**

In 2001 the Netherlands passed statutory law to fit the existing practice of euthanasia but extended it to allow for children as young as 12 to be euthanised subject to parental consent (even in the presence of disagreement between parents).

**Finding 78**

In 2005, the Netherlands endorsed the Groningen Protocol to further extend the practice of euthanasia to younger children, including newborns.

**Finding 79**

Consistent with the Northern Territory experience, assisted suicide in the Netherlands takes place notwithstanding disagreement amongst physicians about patient eligibility.

**Finding 80**

Doctor shopping in the Netherlands has now become commercialised by the emergence of at least one private organisation who will provide assisted suicide to patients whose own physician has declined.

**Finding 81**

The latest frontier in the Netherlands is a debate on whether assisted suicide should be extended to those who are 'tired of life.'

**Finding 82**

In the Netherlands in 2011, the Regional Euthanasia Review Committee found that the attending physician failed to accurately diagnose the patient's back pain.

**Finding 83**

In the Netherlands in 2012, the Regional Euthanasia Review Committee found that two cases of patients with dementia were not handled with due care.

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### **Finding 84**

In the Netherlands in 2013, an assisted suicide took place of a patient who had a broken thigh following an attempted suicide.

### **Finding 85**

In the Netherlands in 2014, the assisted suicide of a woman over 80 years of age with chronic depression took place on the certification of a physician who was not a psychiatrist, who did not consult psychiatrists and was unaware of the Dutch Psychiatric Association Guidelines.

### **Finding 86**

In the Netherlands in 2015, the Regional Euthanasia Review Committee found a lack of due care on a euthanasia carried out on a woman with a history of stomach pains from an undiagnosed cause.

### **Finding 87**

In the Netherlands in March 2018, criminal investigations were confirmed as having been launched into four cases of euthanasia in 2017.

### **Finding 88**

The defence of necessity also exists in Western Australian common law. It has, however, been expressly excluded as a defence to both homicide and euthanasia.

### **Finding 89**

The experience observed of assisted suicide in the Netherlands demonstrates an incremental extension in the practice of assisted suicide, the commercialisation of doctor shopping, and the reality that no redress is available when safeguards inevitably fail.

### **Recommendation 14**

The Government and the Parliament of Western Australia should rule out introducing any assisted suicide regime based on the Netherlands experience.

## **The European Experience—Belgium**

### **Amendment of the law to extend euthanasia to children**

- 3.82. In May 2002, the Belgian parliament approved a law on euthanasia, hereafter referred to as the Euthanasia Act 2002.<sup>595</sup> This Act allowed for the euthanasia of patients in ‘constant and unbearable physical or mental suffering that cannot be alleviated.’ Minors

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595 Actes parlementaires du Sénat de Belgique 2001–2002, Bruxelles, 2002; number 2–244/26.

were included in the original proposals but removed from the final legislation in the face of political opposition.<sup>596</sup>

- 3.83. In February 2014 Belgium amended its law to extend the right to request euthanasia to terminally ill children. Belgium is the only jurisdiction to have legislatively removed all reference to an age restriction (in the Netherlands, by comparison, children must, in theory by statute law, be over the age of 12). This amendment permits children of any age to request euthanasia provided that they understand the consequences of their decision as verified and certified by a child psychiatrist or psychologist. The child must be in a 'medically futile condition of constant and unbearable physical suffering that cannot be alleviated and that will result in death in the short term' and, although no age restriction is given, the child must also display the 'capacity of discernment' and be 'conscious at the moment of making the request.'<sup>597</sup>
- 3.84. It was noted at the time of the amendment's passage that 'for a society, like Belgium, which tolerates euthanasia in certain defined circumstances already, to deny children with capacity the same opportunities to end their suffering humanely, to the same extent as their older contemporaries, must surely be as unjust as it is discriminatory.'<sup>598</sup>

#### **Euthanasia for psychiatric illness**

- 3.85. Like the Netherlands, Belgium also allows euthanasia for people diagnosed with mental illness. A 2015 report investigating the deaths of 100 people by euthanasia for mental illness found that women are more vulnerable to being killed for their poor mental health in Belgium. Of the 100 cases, 11 patients were under 30 years of age (with the average age of death in the cohort being 47 years). The conditions for which requests were considered included: depression, bipolar, schizophrenia, Asperger's syndrome (19 cases); post-traumatic stress disorder; complicated grief; eating disorders; obsessive-compulsive disorders; anxiety; and attention deficit hyperactivity disorder.

*In total, 48 of the 100 patients' euthanasia requests were accepted (48%), because [the psychiatrist], in discussion with the patients' other practitioners and families, considered the requests to be based on reasons that were sufficiently tangible and reasonable, and because all legal requirements had been fulfilled.*<sup>599</sup>

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596 Chandrika Narayan, 'First child dies by euthanasia in Belgium,' *CNN*, 17 September 2016.

597 Euthanasia Act 2002, section 3§1.

598 Samanta J (2015) 'Children and euthanasia: Belgium's controversial new law,' *Diversity and Equality in Health and Care* 12(1) 4-5.

599 Thienpont et al (2015) 'Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study,' *BMJ Open* 5:e007454, quoted in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 9.

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- 3.86. A total of 124 people were killed by euthanasia in Belgium in 2014 and 2015 for mental and behavioural disorders, including depression (41); dementia (36); borderline personality disorder (14); bipolar disorder (9); obsessive-compulsive disorder (5); personality disorder (3); post-traumatic stress disorder (1); psychosis (1); schizoaffective disorder (1); and anorexia (1).<sup>600</sup> This figure of 124 people euthanised for mental and behavioural disorders in Belgium in 2014 and 2015 represents 3.1 per cent of all euthanasia cases in Belgium in that time period (3,950 total cases).<sup>601</sup>
- 3.87. Euthanasia was even approved for a 24-year-old woman in Belgium, known as Laura, on the sole grounds of her mental suffering based on suicidal ideation.<sup>602</sup> Where euthanasia for ‘unbearable psychological suffering’ is legal, psychiatrists are tasked both with preventing suicide, and acting as gatekeepers to euthanasia.<sup>603</sup> The approval of euthanasia for suicidal ideation is of deep concern. Dr Paul Appelbaum, Chair of the World Psychiatric Association’s ethics committee, asks ‘Will psychiatrists conclude from the legalisation of assisted death that it is acceptable to give up on treating some patients?’<sup>604</sup>
- 3.88. Mr Charles Lane suggests that some doctors already have given up on treating their patients. He cites the example of Tine Nys in Belgium. In 2009, 37-year-old Ms Nys became distraught after a romantic breakup and began seeking the assistance of a doctor to euthanise her. Ms Nys had a history of mental illness, including a teenage suicide attempt, but had been doing well more recently. In February 2010 she received a diagnosis of autism, and two months later was administered with a lethal injection.<sup>605</sup>
- 3.89. Belgian mental health professionals, ethicists and physicians have published a call to ban euthanasia for the mentally ill. As of 10 July 2018, the ‘Review Belgian Euthanasia Law for Psychic Suffering’ (REBEL) petition contained the signatures of 252 Belgian clinicians against the practice.<sup>606</sup>

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600 Federale Controle- en Evaluatiecommissie Euthanasie, Zevende verslag aan de Wetgevende Kamers (2014 – 2015), 7 Oct 2016 at 8 and 38, cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 8-9.

601 Dwight Randal, President, Coalition for the Defence of Human Life, JSCEOLC Response to Questions on Notice, 17 April 2018 at 2.

602 ‘Healthy Woman Will Die By Doctor-Assisted Euthanasia Over Suicidal Thoughts,’ *Inquisitor*, 24 June 2015, cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 8.

603 Jamie Hale, ‘We’re told we are a burden. No wonder disabled people fear assisted suicide,’ *The Guardian*, 1 June 2018.

604 Paul S Appelbaum (2016) ‘Physician-Assisted Death for Patients With Mental Disorders – Reasons for Concern,’ *JAMA Psychiatry* 73(4) 325-326.

605 Charles Lane, ‘Doctors Decided Man With Autism Couldn’t Be Treated So They Euthanised Him,’ *LifeNews*, 19 June 2018.

606 ‘Review Belgian Euthanasia Law for Psychic Suffering,’ (REBEL) <<https://www.rebelpsy.be>>

### Polypathology

- 3.90. Section 3.1 of Belgium’s Act on Euthanasia prescribes that the patient be ‘in a medically futile condition... resulting from a serious incurable disorder caused by illness or accident.’ The evidence from Belgium is that this phrase is capable of very broad application and a new category of ‘polypathology’ has arisen for which patients can request euthanasia. In 2015 there were 299 cases of reported euthanasia for non-terminal conditions (14.8 per cent of all cases). These cases included 107 cases of ‘polypathology’ where death was not expected soon and there was no particular major illness or disorder, as well as 57 cases of mental or behavioural disorders. Additionally there was one case of euthanasia for a congenital abnormality or chromosomal disorder.<sup>607</sup>
- 3.91. The Euthanasia Evaluation and Control Commission describes ‘polypathology’ as including situations where mobility difficulties, increasing deafness or loss of vision have led to loneliness, social isolation or a decreased ability to engage in various activities as sufficient justification for euthanasia. Urinary or fecal incontinence, described as a loss of dignity, is also mentioned in this context.<sup>608</sup>
- 3.92. Belgium’s euthanasia law has been broadly interpreted to allow for the euthanasia of a victim of sexual abuse, the euthanasia of a patient suffering from gender dysphoria and even the preliminary approval of euthanasia for an inmate as an alternative to life imprisonment:

*In late 2012 a 44 year old woman known as Ann G was euthanased by her psychiatrist on the grounds of unbearable psychological suffering. She had been treated for anorexia since her teenage years by psychiatrist Walter Vandereycken. In 2008 she publicly accused Vandereycken of sexual abusing her under the guise of therapy. In October 2012 he admitted to years of sexual abuse of several of his patients. Following this admission Ann G spoke of some temporary relief from “the cancer in her head” but subsequently persisted in her request for euthanasia.*<sup>609</sup>

*On 30 September 2013 Nathan Verhelst was euthanased on the grounds of unhappiness following a sex change operation. Nathan (previously known as Nancy) had been rejected by a family who hated girls. Commenting on the euthanasia Nathan’s mother said: “When I saw*

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607 Federale Controle- en Evaluatiecommissie Euthanasie, Zevende verslag aan de Wetgevende Kamers (2014 – 2015), 7 Oct 2016 at 10, cited in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 19.

608 Ibid at 28, cited in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 20.

609 ‘Patiënte van psychiater Vandereycken krijgt euthanasia’ *De standard*, 28 January 2013, cited in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 20.

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*'Nancy' for the first time, my dream was shattered. She was so ugly. I had a phantom birth. Her death does not bother me.*<sup>610</sup> *The doctors who approved and carried out euthanasia on Nathan Verhelst effectively affirmed the rejection Nathan had experienced since childhood.*<sup>611</sup>

*On 15 September 2014 the Brussels Court of Appeal decided that Frank Van Den Bleeken, who has been detained since the 1980s as a mentally impaired man accused of rape and murder, could legally request euthanasia as an alternative to life in prison.*<sup>612</sup> *His euthanasia was scheduled for 11 January 2015 but was halted after the doctors treating him decided not to go ahead with it.*<sup>613</sup>

- 3.93. It has also been considered in Belgium whether euthanasia should be available to a man who had requested euthanasia on the grounds of his sexual attraction to men:

*In June 2016 the BBC interviewed a 39 year old Belgian man, known as 'Sebastien,' who was in the process of being assessed for euthanasia on the grounds of his sexual attraction to men which he said he had never accepted and found unbearable. The outcome of his assessment has not been reported. However, Gilles Genicot, a member of Belgium's Federal Euthanasia Evaluation and Control Commission, commented "It's more likely he has psychological problems relating to his sexuality. I cannot find a trace of actual psychic illness here. But what you cannot do is purely rule out the option of euthanasia for such patients. They can fall within the scope of the law once every reasonable treatment has been tried unsuccessfully and three doctors come to the conclusion that no other option remains."*<sup>614</sup>

- 3.94. It is also alarming to note that the Belgian Society of Intensive Care have endorsed doctors' participation in actively shortening the dying process using sedatives 'in the absence of discomfort.'<sup>615</sup>

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610 Bruno Waterfield 'Mother of sex change Belgian: "I don't care about his euthanasia death,"' *The Telegraph* 2 October 2013, cited in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 20.

611 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 20.

612 'Belgian murderer Van Den Bleeken wins "right to die,"' *BBC News Europe* 15 September 2014, cited in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 21.

613 'Belgian rapist Van Den Bleeken refused "right to die,"' *BBC News Europe* 6 January 2015, cited in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 21.

614 Jonathan Blake 'Man seeks euthanasia to end his sexuality struggle,' *BBC News* 9 June 2016, cited in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 20-21.

615 Sprung et al (2018) 'Physician-Assisted Suicide and Euthanasia: Emerging Issues from a Global Perspective' *Journal of Palliative Care* [sagepub.com/journalsPermissions.nav](http://sagepub.com/journalsPermissions.nav) DOI:



### Use of life-ending drugs without explicit request

- 3.95. In a 2010 study, Chambaere et al studied the incidence of the use of life-ending drugs without an explicit request from the patient and note that this occurred in 1.8 per cent of all deaths in Flanders in the study period.<sup>616</sup> In cases where the decision to administer euthanasia was not discussed with the patient, the physician specified that the reason it was not discussed with the patient was because the patient was comatose (70.1 per cent of cases) or had dementia (21.1 per cent of cases). Physicians specified that the decision had not been discussed with the patient because the decision was in the patient's best interest (17 per cent) or because discussion would have been harmful (8.2 per cent). Compared with voluntary euthanasia or assisted suicide explicitly requested, pain and the patient's wish for ending life were more often reasons for carrying out euthanasia or assisted suicide, whereas family burden and the consideration that life was not to be needlessly prolonged were more often reasons for using life-ending drugs without explicit patient request (or non-voluntary euthanasia).<sup>617</sup>
- 3.96. Mr Denton takes issue with the characterisation of 'the use of life-ending drugs without explicit patient request' as non-voluntary euthanasia. He suggests that the data is influenced by the possibility that many of these actions could have been the administration of palliative sedation to a patient at end of life, a standard palliative care practice.<sup>618</sup> This is not supported by evidence from the report itself, where it clearly states that life-ending drugs were administered to kill the patient without the patient's explicit consent. Palliative sedation does not involve the administration of life-ending drugs to kill the patient, as has already been outlined earlier in this Report.
- 3.97. Chambaere et al note that voluntary euthanasia and assisted suicide were typically performed in younger patients, patients with cancer and patients dying at home which was consistent with findings from other studies. They found that the use of life-ending drugs without explicit patient request occurred predominantly in hospital settings and among patients 80 years of age or older who were in a coma or had dementia, with the authors concluding that this cohort of people could be described as 'vulnerable' patient groups at risk of life-ending without request.<sup>619</sup> Nurses were more often involved in the administration of the drugs when there was no explicit request from the patient than in cases of voluntary euthanasia or assisted suicide.<sup>620</sup>

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10.1177/0825859718777325 4 – citing Vincent et al (2014) "“Piece” of mind: end of life in the intensive care unit statement of the Belgian Society of Intensive Care Medicine,' *J Crit Care* 29(1) 174-5.

616 Chambaere et al (2010) 'Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey,' *CMAJ* 182(9) 895-901.

617 Ibid.

618 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 6. Part E 17.

619 Chambaere et al (2010) 'Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey,' *CMAJ* 182(9) 895-901.

620 Ibid.

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- 3.98. The authors note that the use of life-ending drugs without a patient's explicit request occurred more often in Flanders, Belgium, than in other countries, including the Netherlands. They suggest that Flemish physicians have been shown to be more open to this practice than physicians elsewhere, suggesting a larger degree of paternalistic attitudes. The authors note that the occurrence of this practice has not increased since legalisation, and that the rate has in fact dropped slightly, in line with a similar reduction in the Netherlands. They conclude however that although legalisation of euthanasia seems to have had an impact, more efforts are needed to further reduce the occurrence of life-ending drug use without an explicit request from the patient in Belgium.<sup>621</sup>

### **Euthanasia and palliative care in Belgium**

- 3.99. Requests by the Belgian palliative care community at the time of drafting the Belgian euthanasia laws to include an obligatory palliative care consultation ('palliative filter') were denied. From 2002 to 2007 in Belgium, a palliative care physician was consulted (as a second opinion) in only 12 per cent of all cases of euthanasia. Palliative care physicians and teams were not involved in the care of more than 65 per cent of cases receiving euthanasia. Moreover, the rates of palliative care involvement have been decreasing. In 2002, palliative care teams were consulted in 19 per cent of euthanasia cases, but by 2007 such involvement had declined to 9 per cent of cases. Pereira suggests that this finding contradicts claims that legalisation in Belgium has been accompanied by significant improvements in palliative care.<sup>622</sup>
- 3.100. Pereira notes that a network of physicians trained to provide the consultation role when euthanasia is sought in Belgium has been established, and is known as the Life End Information Forum (leif). Their role includes ensuring that the person is informed of all options, including palliative care. However, Pereira notes that most leif physicians have simply followed a 24-hour theoretical course, of which 3 hours are related to palliative care, which is hardly sufficient to enable a leif member to provide the adequate advice on a patient's complex palliative care needs.<sup>623</sup>

### **Finding 90**

Similar to the Netherlands, Belgium allows assisted suicide for patients diagnosed with a mental illness.

### **Finding 91**

The abuse of practice in Belgium, including approval on the grounds of suicidal ideation, has led to at least 252 Belgian clinicians calling for a review of the law on assisted suicide.

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621 Ibid.

622 Pereira J (2011) 'Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls,' *Current Oncology* 18(2) 38-45.

623 Pereira J (2011) 'Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls,' *Current Oncology* 18(2) 38-45.

**Finding 92**

In Belgium in 2012, a 44-year-old woman was euthanised by her psychiatrist on the grounds of unbearable psychological suffering notwithstanding her history of sexual abuse by a psychiatrist under the guise of therapy.

**Finding 93**

In Belgium in 2013, an adult male who had undergone gender reassignment surgery was euthanised on the grounds of unhappiness, notwithstanding that the patient's family had rejected him from birth due to his female biology.

**Finding 94**

Belgian physicians the subject of a peer-reviewed study in 2010 confirmed the use of life-ending drugs without an explicit request from the patient, including because they considered discussion would have been harmful or because they considered the decision was in the patient's best interest.

**Finding 95**

The experience observed of assisted suicide in Belgium demonstrates an extension in the law and practice of assisted suicide, the inadequacies of safeguards and the undeniable reality that no redress is available to patients after the event.

**Recommendation 15**

The Government and the Parliament of Western Australia should rule out introducing any assisted suicide regime based on the Belgian experience.

**The European Experience—Switzerland**

- 3.101. The Committee sought out the opinions and experience of Mr Minelli, founder of Dignitas, Switzerland, and Mr Luley, Dignitas Board Member. Mr Minelli and Mr Luley were in fact some of the few people called upon by the Committee to give evidence in two separate hearings.
- 3.102. Dignitas operates under a unique legalisation model. Jurisdictions with legalised assisted suicide usually have prescribed safeguards in place, restricting eligibility and requiring consultations with physicians. In Switzerland, however, the penal code allows for a person to assist another to suicide by omission. The *Swiss Criminal Code 1937* Article 115 reads:

*Inciting and assisting suicide—Any person who for selfish motives incites or assists another to commit or attempt to commit suicide shall, if that other person thereafter commits or attempts to commit suicide, be liable to a custodial sentence not exceeding five years or to a monetary penalty.*

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- 3.103. Prosecution can only occur where selfish motive can be proved, or where doubt is raised as to a person's competence to make an autonomous choice to suicide.
- 3.104. In the absence of legislation, the practice of assisted suicide in Switzerland is unregulated and has been extended from the terminally ill to the very ill facing extreme suffering, to the elderly suffering the effects of old age or a combination of illnesses and to those who are physically healthy.<sup>624</sup>
- 3.105. Mr Luley confirmed that by law, assisted suicide can be offered to anyone:

*Hon NICK GOIRAN: That is very helpful. So there have never been any restrictions in Switzerland with regard to access to this. I think it is the case that some people have sought assisted suicide, or accompanied suicide, in Switzerland but been refused. Is that true?*

*Mr LULEY: Yes, because it is in the free decision of a medical practitioner—a physician—to decide whether he wants to give access to assisted dying; whether he wants to write a prescription for the pentobarbital or not. As you can guess, every medical doctor, when a perfectly healthy person and a mentally healthy person would come and would say, "I want to have an accompanied suicide," and the doctor would say, "What's wrong with you? You probably are in a life crisis. You certainly need treatment, but you don't need an assisted suicide. Let's talk about this first and see how we can improve your quality of life so you can get back on track." No Swiss doctor would ever write a prescription for [indistinct]. Theoretically, by law—just theoretically—the doctor could do so. He might get into conflict with the professional board of medical doctors, he might get into conflict with some, let us say, ethics committees or whatever, but based simply on the law a doctor could do so, but it would be against any logic to do that. It is the same for us as an organisation. It might sound provocative to you, but we at Dignitas could do an accompanied suicide for someone who is perfectly healthy, who has no medical diagnosis whatsoever. The law would allow that, but it is understood that no—as long as the person of course has mental capacity—that is always the base; that is understood—but nobody would ever do that.<sup>625</sup>*

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624 Andreas Brunner, Zurich chief public prosecutor, quoted by Clare O'Dea in 'Finding a place for assisted suicide in society,' 9 July 2012 <[http://www.swissinfo.ch/eng/dying-with-dignity\\_finding-a-place-for-assisted-suicide-in-society/32986262](http://www.swissinfo.ch/eng/dying-with-dignity_finding-a-place-for-assisted-suicide-in-society/32986262)>

625 Mr Luley, Board member, Dignitas, Switzerland, JSCEOLC Transcript, 9 April 2018, Session 2 at 4-5 (emphasis added).

- 3.106. Mr Luley suggested that the person must be ‘unhealthy’ in some way in order to be assisted to suicide in Switzerland, meaning that ‘there must be some sort of medical diagnosis, a certain severeness of suffering... Whether it is physical or mental health suffering, it does not matter. Both have the right to access assisted dying in Switzerland.’<sup>626</sup>
- 3.107. Mr Luley was asked by Hon Nick Goiran if there had ever been a case of an accompanied suicide of a healthy person by Dignitas, to which Mr Luley gave the reply ‘Never, ever.’<sup>627</sup> This is intriguing since Italian magistrate Pietro d’Amico was euthanised in Switzerland after a wrong diagnosis from Italian and Swiss doctors. An autopsy conducted at the request of the deceased’s family revealed that he was not suffering from a life-threatening illness at the time of his death.<sup>628</sup>
- 3.108. That ‘suffering’ is also widely interpreted in Switzerland is clear in a statement made by Dr Nitschke to the Committee. Referring to the case of Dr Goodall, Dr Nitschke urged the Committee to consider endorsing the Swiss model here in Western Australia:

*I would urge the Western Australian Parliament to consider [the Swiss legislative model, which] allows for a person to say, “Look, I’ve reached the end of my very productive life and now is the time to die. In other words, it’s my right to have access to the best drugs.” In Switzerland [Dr Goodall] will get the best drugs. Now we are trying to work out the logistics of trying to get this very important person through the very difficult journey, of course, some many thousands of kilometres away. Unfortunately, the only option left in a country like Australia is that a person will have to go and die in a strange place.*<sup>629</sup>

### **Dignitas—helping people suicide**

- 3.109. Mr Luley’s evidence that Dignitas would never assist in the suicide of a healthy person, despite the fact that this would be permitted under Swiss law, is contradicted by his own statement to the Committee that:

*Dignitas is a human rights organisation with a human rights approach which puts the focus on where there is a right to life, there must also be a right to end your life when you want it for whatever reason... if you give the right to an extension of life and the right to end your life when you want to end it, then you automatically have to in a way include helping people who want to end their life out of good reason in a*

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626 Ibid at 5.

627 Ibid.

628 Mr Richard Egan, Defend Human Life!, JSCEOLC Submission 5 at 17, citing ‘Aided suicide in question after botched diagnosis,’ *The Local*, 11 July 2013.

629 Dr Nitschke, Exit International, JSCEOLC Transcript, 13 April 2018, Session 1 at 3.

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*professional manner, to make sure that these people would not turn to violent methods, like jumping from a high building or going in front of a train.*<sup>630</sup>

- 3.110. Mr Luley goes further to suggest that a very open assisted suicide law that can be widely interpreted to include anyone, where ‘it does not matter whether they are in a life crisis or whether they have terminal cancer,’ is the best model for suicide prevention:

*In Oregon, the suicide rate has gone up—not much, but it has risen. Here in Switzerland, it has been decreasing. It is logic, from our point of view and our experience, because, quite simply, people who have a real choice and are professionally accompanied and are professionally counselled if they are a patient—it does not matter whether they are in a life crisis or whether they have terminal cancer—when they know they can turn to someone, maybe a physician, maybe an organisation like Dignitas, when they know they can talk openly about it, without [inaudible] and get advice, then they are much less at risk to turn to violent methods. So the best—it might sound provocative, but our experience is that the best suicide prevention and suicide attempt prevention that you can have is if you give as far as possible access to assisted dying, because people then know they can access professional help and have a choice and thus they do not have to turn to violent methods.*<sup>631</sup>

- 3.111. Mr Luley’s words may be interpreted to mean that the suicides of these people were avoided because they were reassured by their ability to access assisted suicide through organisations such as Dignitas in Switzerland, and therefore did not turn to violent methods. That is, since they could be ‘professionally accompanied’ by an organisation like Dignitas, and ‘professionally counselled’ about suicide, they did not turn to suicide as they knew that assisted suicide would be an option for them if the time came.
- 3.112. An alternative interpretation of his words is, however, also open, particularly when read in the context of other statements made to the Committee and historically by Mr Minelli and Mr Luley. This is, that suicide by violent methods has decreased in Switzerland as people turn to organisations like Dignitas for assistance:

*But here in Switzerland, where we definitely have a more progressive legal situation, which gives them more open-minded, more liberal and*

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630 Mr Luley, Board member, Dignitas, Switzerland, JSCEOLC Transcript, 8 March 2018, Session 5 at 2.

631 Ibid at 7 (emphasis added).

*more people access to assisted dying, here the number of violent suicides, has decreased and, yes, the data is available publicly.*<sup>632</sup>

- 3.113. In a 2010 article in *The Atlantic*, Mr Luley is quoted as saying:

*Suicide is not bad... There's nothing wrong with wanting to end your life. Sometimes life is great, sometimes life is shit. I have the right to say that I'm pissed off with my life, and I want to end it.*

...

*Dignitas exists to prevent [failed suicide attempts], to see to it that those wishing to kill themselves may do so without fear of pain or failure. The fact that people lack legal access to a death like this is the group's organising principle.*<sup>633</sup>

- 3.114. Mr Minelli is also quoted as saying that suicide is 'the last human right' and is outspoken in his desire to do away with anything that might restrict the practice of assisted suicide. In an interview with the BBC, he went so far as to call assisted suicide 'a marvellous possibility given to a human being' to escape their suffering.<sup>634</sup>
- 3.115. It is very difficult to see how the 'professional accompaniment' and 'professional counselling' of Dignitas, in light of these statements by Mr Minelli and Mr Luley, could be said to deter people from suicide.
- 3.116. The 2015 Swiss suicide rate of 10.7 per 100,000 (male 15.5, female 6.0) published by the World Health Organisation reveals that the Swiss suicide rate is similar to the rates of neighbouring countries France and Austria, and is higher than that of Germany where the rate is 9.1 per 100,000 (male 13.9 and female 4.5).<sup>635</sup>
- 3.117. The raw, or non-standardised, Swiss suicide rate is somewhat higher. In 2014, 1,029 people committed non-assisted suicide (754 men and 275 women) for a rate of 12.5 per 100,000 (18.5 male, 6.6 female). This statistic does not include the 742 assisted suicides in that same year (320 men and 422 women).<sup>636</sup>

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632 Mr Luley, Board member, Dignitas, Switzerland, JSCEOLC Transcript, 9 April 2018, Session 2 at 3.

633 Falconer, Bruce 'Death Becomes Him' (2010) *The Atlantic*, March Issue  
<<https://www.theatlantic.com/magazine/archive/2010/03/death-becomes-him/307916/>>

634 Ibid.

635 World Health Organization (2015) 'Suicide rate estimates, age-standardized Estimates by country' <<http://apps.who.int/gho/data/node.main.MHSUICIDEASDR?lang=en>>

636 Federal Statistical Office (2014) 'Cause of death statistics 2014: Assisted suicide and suicide in Switzerland,'  
<<https://www.bfs.admin.ch/bfs/en/home/statistics/health.assetdetail.3902308.html>> and  
Federal Statistical Office (2014) 'Switzerland's population 2014,'  
<<https://www.bfs.admin.ch/bfs/en/home/statistics/population.assetdetail.349851.html>>

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- 3.118. The sheer volume of suicides (both assisted and non-assisted) ought to be of great concern.

### **Helium experimentation in Dignitas assisted suicides**

- 3.119. Also of significant concern was evidence to the Committee that Dignitas experimented with helium as a means of death in the assisted suicides of a number of people when the organisation was unable to obtain lethal prescriptions from doctors at one stage.
- 3.120. Suicide organisations in Switzerland who only provide assisted suicide to Swiss residents often obtain lethal prescriptions from doctors who have known their patients for years and are intimately familiar with the details of their medical histories. Dignitas, whose clients are largely foreign, is unable to do so: the consulting physician does not typically have a long history with the person requesting assistance, and the physicians are compelled to make hurried decisions once the person has flown into the country. In 2007 this practice drew harsh criticism in the international press and in response, Zurich's chief physicians increased the requirement to two doctors' appointments. According to a report, Mr Minelli:

*viewed it as a personal attack, and his response was as swift as it was extreme: a series of four 'demonstration' deaths using helium gas. The suicides gave Minelli the opportunity to experiment with new methods and served as a not-so-subtle reminder that, if necessary, he could continue on even without doctors and their sodium pentobarbital.<sup>637</sup>*

- 3.121. Dignitas' experimentation was raised in evidence with Mr Minelli and Mr Luley in a Committee hearing by Hon Nick Goiran MLC:

*Hon NICK GOIRAN: If it is such a good method, why do you not keep using it now?*

*Mr LULEY: Because it is very technical with—well, I do not want to talk about it now, because this is all public. You research it yourself, then you will realise how effective and how efficient and how easy it is. But it is a very technical method, and pentobarbital is a much simpler method, and more aesthetic. If you want to take this way with helium, you must work with a hood, or with a bag over your head, and so on and so on; you need the gas. Think of Europe, where we had the thinking with some older people, going back to the German Deutsches Reich—the Nazis—triggering ideas of that. We do not want to touch that. It works. No doubt about it, it works very well, but it is better not to use that method,*

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637 Falconer, Bruce 'Death Becomes Him' (2010) *The Atlantic*, March Issue  
<<https://www.theatlantic.com/magazine/archive/2010/03/death-becomes-him/307916/>>



*not for medical or technical reasons [inaudible] with having perspective.*<sup>638</sup>

- 3.122. In 2010, Mr Minelli shared details of the helium experimentation with journalist Bruce Falconer, and confirmed that he was pleased with the result:

*I think it is the best method... But it is not nice to see... Muscles are agitated. Eyes open and close. Arms and legs twitch without coordination. And if you are not well informed, you might mistake this for a terrible struggle against death, which it is not. It's just the same as when you cut the head off a chicken.*<sup>639</sup>

- 3.123. Mr Minelli was never prosecuted for these deaths, as presumably the four people who died by helium experimentation had consented to assisted suicide by that method.
- 3.124. More recently, Mr Minelli defended a charge of profiteering. It was alleged that in 2010 Mr Minelli had charged a mother and daughter around 10,000 Swiss francs each for assisted suicide, instead of the usual cost of some 5,000 to 6,000 Swiss francs. In a second case, Mr Minelli was alleged to have taken advantage of an 80-year-old woman who was sick but not terminally ill. He approached four doctors before finally finding one who was willing to assist the woman to suicide. Prosecutors argued that his persistence in the second case was based on the fact that the woman had promised him a donation of 100,000 Swiss francs to Dignitas on her death. They also alleged that she had given Mr Minelli power of attorney, allowing him to transfer 46,000 Swiss francs to a Dignitas account when she died.<sup>640</sup> Prosecutors also alleged that Mr Minelli had not honoured her request to have her ashes buried beside her husband in Germany, but had disposed of them in lake Zurich.<sup>641</sup> The charges of profiteering against Mr Minelli failed. With the high standard of proof in criminal cases, and the fact that the best witness was unavailable, it is no surprise that prosecutions were unsuccessful. This demonstrates the inherent difficulty in testing the integrity of a safeguard after the event. Meanwhile, redress for a victim is an impossibility after the event.
- 3.125. In light of the experience regarding Swiss assisted suicide law and its practice by Dignitas, the WA Parliament should reject the advice of Dr Nitschke. A Swiss model of assisted suicide should not be adopted in Western Australia.

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638 Mr Luley, Board member, Dignitas, Switzerland, JSCEOLC Transcript, 9 April 2018, Session 2 at 10.

639 Falconer, Bruce 'Death Becomes Him' (2010) *The Atlantic*, March Issue  
<<https://www.theatlantic.com/magazine/archive/2010/03/death-becomes-him/307916/>>

640 'Head of Swiss assisted suicide group Dignitas in court on profiteering charges,' *The Local*, 18 May 2018.

641 Justin Huggler, 'Founder of Swiss assisted suicide organisation on trial for profiteering from his clients,' *The Telegraph*, 18 May 2018.

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### Finding 96

Assisted suicide in Switzerland is based on a penal code that allows, by omission, for a person to assist another to suicide.

### Finding 97

At least four assisted suicides in Switzerland have occurred while practitioners experimented with the use of helium, which results in agitated muscles, eyes opening and closing, and arms and legs twitching without coordination.

### Finding 98

In Switzerland in April 2013, a retired Italian magistrate, aged 62, was assisted to suicide on the basis of a terminal illness diagnosed by Italian and Swiss doctors only for an autopsy to find no terminal illness.

### Finding 99

The experience observed of assisted suicide in Switzerland underscores the inherent difficulty in testing the integrity of safeguards after the event whilst re-confirming the impossibility for redress by the victim after the event.

### Recommendation 16

The Government and the Parliament of Western Australia should reject the advice of Dr Nitschke and rule out introducing an assisted suicide regime based on the Swiss model.

## The North American Experience—Canada

- 3.126. In evidence to the Committee, Mr Walker of Dying with Dignity (WA) asserted that the Canadian model of legalised assisted suicide is workable, and one that should be considered for introduction here in Western Australia:

*Canada is surely a most useful parallel for us to consider; it is by no means a harebrained scheme. It has been adopted. It is working and we suggest it is the best model to follow.*<sup>642</sup>

- 3.127. A legislative assisted suicide model was introduced in Canada following the Supreme Court ruling in *Carter v Canada (Attorney General)*,<sup>643</sup> which held that the current blanket prohibition on assisted suicide breached the right to life. This decision overturned the existing law made in the 1993 decision of the Court in *Rodriguez v Canada* in which the Court had held that the prohibition of assisted suicide in the Criminal Code was not contrary to the Canadian Charter of Rights and Freedoms. The court's 2015 reasoning

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642 Mr Walker, Vice President, Dying with Dignity (WA), JSCEOLC Transcript, 13 April 2018, Session 5 at 4.

643 [2015] 1 SCR 133.

included that, where suicide is legally permitted but ‘assisted dying’ is not, some individuals may die earlier than they would if ‘assisted dying’ were permitted—that is, they may suicide before they would request assisted suicide because they fear losing the physical capacity to suicide unassisted and being trapped with no way out.<sup>644</sup>

### Expansion of the model

- 3.128. It is interesting that Dying with Dignity WA recommend the Canadian model for adoption here in Western Australia, commending it as ‘the best model to follow,’ whilst implicitly criticising the model as more conservative than the Supreme Court’s determination allowed for in the *Carter* decision. Mr Walker states that ‘more litigation is going on in Canada now, seeking to challenge the conservative nature of the Canadian Act.’<sup>645</sup>
- 3.129. In June 2016, a Bill C-14 was passed in Canada’s Parliament to legalise and regulate assisted suicide in that country, or what is termed ‘Medical Assistance in Dying’ (MAID). The legislation specifies that a person must be facing a ‘reasonably foreseeable natural death,’ however within one year of Bill C-14’s passage through Parliament, the Supreme Court of Ontario had issued an interpretation of this provision that expanded the application of assisted suicide to cover people who are not terminally ill but who have an irreversible, deteriorating chronic illness, even if that condition will not of itself cause death.<sup>646</sup>
- 3.130. Calls are also being made for the scope of the law to be extended to include the assisted deaths of children and teenagers. A survey by the Canadian Pediatric Surveillance Program observed that 118 pediatricians confirmed that they had had exploratory conversations with children, teenagers and parents about assisted dying for minors.<sup>647</sup> In December 2016, only months after the C-14 Bill was passed, Health Canada had commissioned a committee of experts to consider the extension of the current laws to include mature minors.<sup>648</sup> A Canada Health media release stated:

*On behalf of the Government of Canada, Minister of Health Jane Philpott and Minister of Justice and Attorney General of Canada Jody Wilson-Raybould are pleased to announce that they have engaged the*

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644 Willmott and White (2017) ‘Assisted Dying in Australia: A Values-based Model for Reform,’ in *Tensions and Traumas in Health Law* at 489-90, submitted in Professors Willmott and White, Directors, Australian Centre for Health Law and Research and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, JSCEOLC Submission 560A.

645 Mr Walker, Vice President, Dying with Dignity (WA), JSCEOLC Transcript, 13 April 2018, Session 5 at 4.

646 *AB v Canada (Attorney General)* 2017 ONSC 3758, 19 June 2017, cited by Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 13-14.

647 Aaron Derfel ‘Physician-assisted deaths have jumped 282% in one year: commission,’ *Montreal Gazette*, 26 October 2017.

648 Charles Lewis ‘How crazy is it to encourage the mentally ill to kill themselves?’ in *National Post*, 14 June 2018.

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*Council of Canadian Academies (CCA) to conduct independent reviews related to specific types of requests for medical assistance in dying. The three reviews will focus on requests by mature minors, advance requests, and requests where mental illness is the sole underlying medical condition.*<sup>649</sup>

- 3.131. In 2017, a 27-year-old Canadian man named Adam Maier-Clayton took his own life. He suffered from mental illness and had written about wanting a legal way to end his suffering and his life in a *Globe* essay months before his death. Mr André Picard, *The Globe and Mail's* health reporter, wrote a column that urged lawmakers to heed to Mr Maier-Clayton's wish in honour of his tragic death:

*Other Canadians who want to avail themselves of assisted death shouldn't have to wait either for legislation to catch up with the court ruling and public sentiment. Most people accept that if someone's dying anyhow, it's OK to hasten their death, especially if they're old. But cases such as Mr. Maier-Clayton's make us distinctly uncomfortable. He was young, healthy-looking and not suffering from any obvious physical illness. We should not discriminate or deny people rights because it makes us queasy or because of our prejudices. This case reminds us just how severe mental illness can be.*<sup>650</sup>

- 3.132. In a survey study released in September 2017, an overwhelming majority of Quebec caregivers said they favour extending medical aid in dying to those afflicted with Alzheimer's disease or dementia (Canadian law presently requires that the patient who makes the request must do so 'in a free and informed manner,' thereby excluding those with dementia.) The survey by Université de Sherbrooke epidemiologist Professor Gina Bravo found that 91 per cent of respondents support the idea of assisted dying for individuals suffering from dementia who are at the terminal state of their illness, showing signs of distress and who have an advance written directive. Furthermore, 72 per cent said they were for assisted dying even for Alzheimer's patients who did not sign a written directive before their illness.<sup>651</sup>
- 3.133. Calls are also being made in Canada for 'death on demand.' Dr Yves Roberts, an advocate for the introduction of assisted suicide legislation in Canada, has published an open letter expressing shock over the developments in the two years since the passage of the C-14 Bill, and the calls now being made for death on demand based on the argument that it is

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649 Health Canada, Government of Canada, 'Government of Canada Initiates Studies Related to Medical Assistance in Dying,' News Release, 13 December 2016 (emphasis added).

650 André Picard 'The mentally ill must be part of the assisted dying debate,' *The Globe and Mail*, 17 April 2017.

651 Aaron Derfel 'Most caregivers favour assisted dying for Alzheimer's patients: survey,' *Montreal Gazette*, 21 September 2017.

discriminatory to require certain conditions to be fulfilled before a doctor can approve the assisted suicide of a patient.<sup>652</sup>

3.134. In February 2018, less than two years after the passing of the C-14 Bill, the Superior Court of Justice Division Court of Ontario ruled on the constitutionality of the ‘Effective Referral Provisions’ of the Human Rights Policy and MAID Policy of the College of Physicians and Surgeons of Ontario. The Effective Referral Provisions require physicians who are unwilling to provide, amongst other matters, MAID to their patients, on moral or religious grounds to provide an effective referral to another health care provider. The ruling forces objecting physicians to refer patients to a physician who will help kill the patient and effectively states ‘that if doctors are unwilling to perform legal actions, they should find another job.’<sup>653</sup> Forced referral was unprecedented in any other jurisdiction with legalised assisted suicide. There is also evidence that Canadian hospices are being bullied into hosting euthanasia, with a recent edict by the Fraser Health Authority in British Columbia ordering (non-religious) healthcare facilities, including hospices, to participate in assisted suicide, which is an infringement on the conscience rights of the medical staff employed at these facilities.<sup>654</sup>

3.135. Canadian bioethicists at the University of Montreal, Ms Julie Allard and Dr Marie-Chantal Fortin, have recently published an article promoting organ donation through the Medical Assistance in Dying program in Canada:

*MAID (medical aid in dying) has the potential to provide additional organs available for transplantation. Accepting to procure organ donation after MAID is a way to respect the autonomy of patients, for whom organ donation is an important value. Organ donation after MAID would be ethically acceptable if the patient who has offered to donate is competent and not under any external pressure to choose MAID or organ donation.*<sup>655</sup>

3.136. Allard and Fortin acknowledge that there might be some ethical complications. Patients might feel that they are a burden and could only be useful if they were to give their

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652 Yves Roberts MD, Secretary, College des medecines du Quebec, ‘Towards death a la carte?’ 10 May 2017 <[https://collectifmedecins.org/en/dr-roberts-regrets/#\\_ftn1](https://collectifmedecins.org/en/dr-roberts-regrets/#_ftn1)>, referred to in evidence by Professor Somerville, Professor of Bioethics, University of Notre Dame Sydney, JSCEOLC Transcript, 1 May 2018, Session 8 at 3.

653 Dwight Randal, President, Coalition for the Defence of Human Life, Presentation to the Select Committee on End of Life Choices, included in JSCEOLC Response to Questions on Notice, 17 April 2018 at 6.

654 Ibid.

655 Allard and Fortin (2016) ‘Organ donation after medical assistance in dying or cessation of life-sustaining treatment requested by conscious patients: the Canadian context,’ *Journal of Medical Ethics* doi:10.1136/medethics-2016-103460.

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organs. This would constitute a subtle form of coercion. However, Allard and Fortin are confident that this can be overcome:

*It will be difficult to disentangle patients' motivations for requesting MAID, but the complete separation of the two decisional processes should help to ensure that the MAID request is motivated by unbearable suffering, as required by law, and not by the feeling that one's value is limited to one's organs.*<sup>656</sup>

- 3.137. Prisoners are also now permitted to access assisted suicide under the MAID legislation in Canada. As at March 2018, one prisoner had already been killed under the legislation, and Correctional Services Canada (CSC) confirmed that it had received eight requests for MAID. CSC is now permitted to organise MAID, or assisted suicide, for a prisoner in a community hospital and also in a penitentiary regional hospital or treatment centre in exceptional circumstances and at the request of the inmate.<sup>657</sup> Correctional Investigator Dr Ivan Zinger criticised the possibility of inmates being euthanised in a prison in a letter to CSC, suggesting that a prohibition on MAID within prisons would protect the integrity of the system now and in the future, when eligibility for assisted death could expand to prisoners suffering from acute psychiatric illnesses.<sup>658</sup>

### **Problems with implementation of the current model**

- 3.138. Calls for expansion aside, there is nothing to indicate that the current legislative model in Canada is workable. Dr Gordon Gubitz, an assisted suicide provider from Canada, gave evidence to the AMA(WA) Symposium on End of Life Choices recently here in Perth, with Dr Khorshid later telling the Committee that:

*in sharing his personal experiences, [Dr Gubitz] was able to make it clear to us that the processes were not terribly robust in Canada... they have work to do before they have a system that they would promote to other countries as being good.*<sup>659</sup>

- 3.139. Issues around process, infrastructure, funding and reporting in Canada were identified by Dr Khorshid in evidence to the Committee.<sup>660</sup>
- 3.140. Concern has also been raised over the rate at which assisted suicide is increasing in Canada, where deaths through 'Medical Aid in Dying' increase from 167 cases in 2015-2016, to 638 cases in 2016-2017—an increase of 282 per cent.<sup>661</sup> Derfel suggests that

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656 Ibid.

657 Michael Cook, 'Euthanasia performed on Canadian prisoner,' *BioEdge*, 4 March 2018.

658 Ibid.

659 Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 18 May 2018, Session 1 at 17.

660 Ibid at 4.

661 Aaron Derfel, 'Physician-assisted deaths have jumped 282% in one year: commission,' *Montreal Gazette*, 26 October 2017.

this increase highlights the growing popularity of assisted suicide in Quebec, but also raises questions about whether the rules are being followed properly.<sup>662</sup>

- 3.141. Whether the rules are being followed in Canada is not a hypothetical question, as the province of Quebec illustrates. Before the passage of Bill C-14 federally, assisted suicide legislation was passed in the Canadian province of Quebec on 5 June 2014.<sup>663</sup> This measure was challenged by the Canadian federal government, but in December 2015 the Quebec Court of Appeal confirmed that the legislation would stand in light of the Canadian Supreme Court's *Carter* decision.<sup>664</sup>
- 3.142. In the first nine months following the passage of the Act in Quebec, the Commission sur les soins de fin de vie (CSFV), or End of Life Commission, found that one of the requirements of the legislation was not met in 21 cases of physician-assisted dying. Among the requirements not met, the main concerned the independence of the second doctor (18 cases). The others related to end-of-life criteria (two cases) and to the attainment of a serious and incurable illness (one case), as defined by Quebec law.<sup>665</sup>
- 3.143. In response to these breaches of the legislative requirements, the Minister for Health and Social Services stated:

*These data demonstrate the vital work done by the Commission on end-of-life care. The vast majority of physician-assisted dying, 85%, was administered in accordance with the requirements of the Act and we must remain vigilant with respect to the conditions of administration. The figures presented in this report reflect the first few months of application of the Act, which is, in a way, a period of learning and adaptation for the actors concerned. Over the next few months, we will strive to resolve the adjustment difficulties and we will ensure that each stakeholder understands the requirements of the Act.*<sup>666</sup>

- 3.144. This strive to resolve 'adjustment difficulties' and to 'ensure that each stakeholder understands the requirements of the Act' did not produce results.
- 3.145. In the second year of the Quebec Act's operation, the Commission was unable to conclude compliance with the legislative requirements in 3 per cent of the case reports provided to the Commission (19 case reports), due to incomplete information provided

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662 Ibid.

663 Bill 52, also known as 'An Act respecting end-of-life care,' National Assembly, Quebec.

664 [2015] 1 SCR 133.

665 Office of the Minister of Health and Social Services, 'Minister Gaetan Barrett releases the Commission's first report on end of life care,' Media Release, Quebec, 27 October 2016 <<https://www.newswire.ca/fr/news-releases/le-ministre-gaetan-barrette-rend-public-le-premier-rapport-de-la-commission-sur-les-soins-de-fin-de-vie-598891241.html>>

666 Ibid (emphasis added).

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by the attending physician in those reports. The Commission also concluded that in 31 cases of physician-assisted death, the legislative requirements were not met in this twelve month period. Again, among the requirements not met, the main one in 20 cases concerned the independence of the second doctor. In seven cases, the doctor who administered euthanasia failed to have a conversation with the patient to verify that the request was free and informed, that suffering was persistent and to verify the consistency of the wish to die. In one case in this 12-month period the patient did not have a serious and incurable illness.<sup>667</sup>

- 3.146. It seems that the Minister of Health and Social Services has now given up trying to ensure compliance with the Act with regard to the most frequent compliance problem in Quebec, that is, the lack of an independent second doctor:

*Since February 2017, the [End of Life] Commission has adapted its assessment of this criterion in the light of ongoing work in partnership with the MSSS [Ministère de santé et services sociaux (Ministry of Health and Social Services)] and the CMQ [Collège des Médecins du Québec (College of Physicians of Quebec)]. These cases would now be considered compliant, as long as the other criteria are met.<sup>668</sup>*

- 3.147. The province of Quebec illustrates clear breaches of the legislative requirements in that jurisdiction, and a seeming lack of will on the part of the government to ensure compliance.

- 3.148. Meanwhile, evidence was also given by Dr Gubitza in his practice of assisted suicide in Canada, that some of the patients who requested his assistance had not received any palliative care.<sup>669</sup> Dr Craig Sinclair, Research Fellow at UWA, gave evidence to the Committee that he was:

*supportive of the rights-based approach that is taken in Canada and established in Carter v Canada. I believe that an approach grounded in the principles of autonomy and equality of access to assisted dying would be preferential. Within such an approach, the safeguarding that*

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667 Office of the Minister of Health and Social Services, 'Minister Gaetan Barrette tables Commission Report on End-of-Life care,' Media Release, Quebec, 26 October 2017 <<https://www.newswire.ca/fr/news-releases/le-ministre-gaetan-barrette-depose-le-rapport-de-la-commission-sur-les-soins-de-fin-de-vie-653342363.html>>; and Amy Hasbrouk, 'Quebec euthanasia data from the Commission on end-of-life care,' *Euthanasia Prevention Coalition*, 31 October 2017 <<https://alexschadenberg.blogspot.com/2017/10/euthanasia-report-from-commission-on.html>>

668 Footnote (a) at page 22 of the Commission sur les soins de fin de vie Report tabled in the Quebec National Assembly, 26 October 2017, cited in Amy Hasbrouk, 'Quebec euthanasia data from the Commission on end-of-life care,' *Euthanasia Prevention Coalition*, 31 October 2017 <<https://alexschadenberg.blogspot.com/2017/10/euthanasia-report-from-commission-on.html>>

669 Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 18 May 2018, Session 1 at 7.



*we might think about when looking at safeguarding assisted dying would give its attention to safeguarding the integrity of the decision-making process, rather than providing a criminal defence for the medical practitioner. That would include things such as having access to genuine alternatives—the example being someone in a remote area who does not have access to palliative care; potentially you could say that the decision-making process is compromised in that situation.*<sup>670</sup>

- 3.149. Patient-rights advocates in Canada have expressed concern that the dramatic increase in the number of cases of assisted suicide partly reflects the reality that palliative care is lacking in some parts of Quebec and the living conditions in long-term care centres are far from ideal.<sup>671</sup>
- 3.150. A 2017 study found that the legalization of medical assistance in dying could reduce annual health care spending across Canada by up to \$138.8 million, exceeding the maximum \$14.8 million in direct costs associated with its implementation.<sup>672</sup> This evidence directly contradicts the evidence given to the Committee by Mr Neil Francis that ‘potential savings would be very minor.’<sup>673</sup> Studies suggesting savings in annual health spending in Canada are very worrying, particularly in light of the recent case of Mr Roger Foley, who lives with a cerebellar ataxia (a degenerative neurological condition) and who has launched a lawsuit naming the London Health Sciences Centre and South West Local Health Integration Network in Ontario Canada, stating that they are willing to provide him with assisted death under the MAID legislation, but that they are unwilling to fund his care to provide him with an assisted life.<sup>674</sup>
- 3.151. All of this evidence demonstrates the unsoundness of the recommendation made to the Committee by Dying with Dignity (WA) that the Canadian model is ‘workable’ and the ‘best model to follow.’

### **Finding 100**

In 2016 the Canadian Parliament enacted an assisted suicide law for a person facing a reasonably foreseeable natural death, only to have the Supreme Court of Ontario

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670 Dr Sinclair, Research Fellow, University of Western Australia, JSCEOLC Transcript, 26 February 2018, Session 3 at 12.

671 Aaron Derfel, ‘Physician-assisted deaths have jumped 282% in one year: commission,’ *Montreal Gazette*, 26 October 2017.

672 Sprung et al (2018) ‘Physician-Assisted Suicide and Euthanasia: Emerging Issues from a Global Perspective,’ *Journal of Palliative Care* sagepub.com/journalsPermissions.nav DOI: 10.1177/0825859718777325, at 3 – citing Trachtenberg and Manns (2017) ‘Cost analysis of medical assistance in dying in Canada,’ *CMAJ* 189(3).

673 Mr Neil Francis, Dying for Choice, JSCEOLC Submission 642 at 27.

674 “‘The solution is assisted life’”: Offered death, terminally ill Ont man files lawsuit,’ *CTVNews*, 15 March 2018.

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interpret the provision so as to extend its application to a person not terminally ill but who has an irreversible deteriorating chronic illness.

### **Finding 101**

In late 2016 the Canadian Government commissioned reviews to explore a further extension of assisted suicide laws to minors, to those making an advance request and to those where mental illness is the sole underlying condition.

### **Finding 102**

In February 2018 a Canadian Court has ruled that physicians with a conscientious objection to assisted suicide are nevertheless obliged to refer their patient to a practitioner who will execute the assisted suicide.

### **Finding 103**

In the first nine months following the passage of an assisted suicide law in Quebec it was found the law had been breached in 21 cases. In the second year of operation, breaches occurred in 31 cases.

### **Finding 104**

In the short experience of the Canadian law on assisted suicide there has already been at least one case of a doctor assisting a suicide by lethal injection notwithstanding that the patient did not suffer a serious incurable illness.

### **Recommendation 17**

The Government and the Parliament of Western Australia should reject the advice of Dying with Dignity WA (formerly known as the Western Australian Voluntary Euthanasia Society) and rule out introducing an assisted suicide regime based on the Canadian model.

## **The North American Experience—Oregon**

- 3.152. Proponents of assisted suicide present Oregon as an example of a jurisdiction with a long and successful history, where the scope of the legislation has remained unchanged since its introduction:

*Oregon... is, apart from the Northern Territory, the first operative assisted dying regime in the world. It is the longest standing in operation and it is the one most like the Victorian model. It has not changed in terms of its scope.*<sup>675</sup>

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<sup>675</sup> Prof White, Director, Australian Centre for Health Law Research, JSCEOLC Transcript, 26 February 2018, Session 2 at 11.

- 3.153. Practical issues arising from the Oregon model are not acknowledged and only glowing reviews are offered. Mr Denton, for example, asserted that:

*There is abundant evidence from Oregon to demonstrate that providing legal, regulated access to life-ending medication has strong palliative power and likely helps prolong life.<sup>676</sup>*

- 3.154. There is abundant evidence from Oregon, including case examples, which reveal that there are serious issues with the Oregon model that present significant risk to vulnerable members of the community in that State. These are the cases the proponents will not acknowledge. It is important that the cases are heard, and heeded.

### **Medical errors in prognosis**

- 3.155. The issue of medical error in prognosis has been considered at length in Chapter 2 of this Report. There the Oregon Health Authority data is analysed in detail and reveals that the prognosis of many Oregonians whose assisted suicide was facilitated under the *Dying with Dignity Act* was incorrect.
- 3.156. 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.<sup>677</sup>*

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676 Mr Denton, Go Gentle Australia, JSCEOLC Response to Questions on Notice, 13 May 2018 at 9.

677 Kenneth Stevens ‘Doctor helped patient with cancer choose life over assisted suicide,’ *Missoulian*, 27 November 2012, quoted in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 15.

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### Optional referral for psychiatric assessment

- 3.157. Chapter 2 of this Report addresses the complexity in assessing patient competence in an assisted suicide case. The low rates of referral to a psychiatric specialist under the 'optional referral' model in Oregon is discussed in detail there.
- 3.158. A tragic real-life scenario is presented by Dr Charles J Bentz, who recounts that one of his patients should have received psychiatric care, but was instead offered a lethal prescription:

*In 2011 Dr. Charles J. Bentz of the Division of General Medicine and Geriatrics at Oregon Health & Sciences University explained that Oregon's physician-assisted suicide law is not working well. He 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 underwent therapy, he became depressed, partly because he was less able to engage in hiking. He 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 urges other jurisdictions "Don't make Oregon's mistake."<sup>678</sup>*

- 3.159. The example of the treatment of this 76-year-old Oregonian evidences issues of doctor shopping, issues around the assessment of capacity and the risk that a patient's request for assisted suicide may be influenced by undiagnosed or untreated depression or demoralisation, and issues around doctor bias toward assisted suicide and their willingness to accept a patient's wish to hasten death as a request to die.
- 3.160. Like the evidence given to the Committee by Dr Miller, Consultation Liaison Psychiatrist, Dr H Rex Greene explains that demoralisation syndrome is very common in chronic and life threatening illness:

*the features of which (hopelessness, helplessness, and despair) fit the profile of the victims of Oregon's law, who are consistently reported not*

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678 Charles Bentz 'Oregon's assisted suicide law isn't working,' *The Province*, December 5 2011, quoted in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 5.

*to be in pain or disabled by their allegedly terminal illness but request [assisted suicide] because of fears of... the future: helplessness, dependency, becoming a burden. Oregon in fact has proven that the only symptom driving requests for [assisted suicide] is psychological distress. Clearly the standard of care for depression and demoralization is not a lethal overdose of barbiturates.<sup>679</sup>*

- 3.161. Further evidence from Oregon also demonstrates that the introduction of assisted suicide undermines standards of care offered to patients:

*A woman in her mid-50s with heart disease, but otherwise with no significant pain or mobility limitations, requested a lethal prescription from her cardiologist. The cardiologist, in turn, referred her to another physician who was willing to write lethal prescriptions. This physician determined she was not terminally ill. But rather than ask about the origins of her suicidal wishes and give her a psychiatric referral, the physician simply told her to see her cardiologist again. Her cry for help unanswered, she committed suicide the following day.<sup>680</sup>*

#### **Doctor bias toward euthanasia**

- 3.162. Doctor bias toward granting assisted suicide requests is considered in Chapter 2 of this Report. It was noted there that in Oregon, a physician member of a pro-assisted suicide lobby group provided the consultation in 58 of 61 consecutive cases of patients receiving physician-assisted suicide in Oregon.<sup>681</sup>
- 3.163. Dr Peter Goodwin, Oregon's Compassion & Choices former Medical Director, said that about 75 per cent of reported Oregon assisted suicide deaths in 2002 were undertaken with the organisation's assistance. In 2003, the group was involved in 79 per cent of the assisted deaths that occurred, and 'in 2008 the proportion of Compassion & Choices physician assisted suicide deaths significantly increased to 88% (53/60) of all reported deaths.'<sup>682</sup>

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679 Golden and Zoanni (2010) 'Killing Us Softly: The Dangers of Legalizing Assisted Suicide' *Disability and Health Journal* 3(1) 16-30 at 23, quoting H Rex Greene MD 'Letter to the council on ethical affairs, California Medical Association' 22 February 2006 <<https://dredf.org/public-policy/assisted-suicide/opposition-to-neutrality-on-ab-651/>>

680 Ibid at 24.

681 Hendin and Foley (2008) 'Physician-assisted suicide in Oregon: a medical perspective,' *Mich Law Rev* 106, 1613-40.

682 Golden and Zoanni (2010) 'Killing Us Softly: The Dangers of Legalizing Assisted Suicide,' *Disability and Health Journal* 3(1) 16-30 at 21.

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- 3.164. This raises concerns about the objectivity of the process and the safety of the patients, and raises questions about the influence of bias on the part of these physicians on the process.<sup>683</sup>

### **Doctor shopping**

- 3.165. The first known assisted suicide death under the Oregon statute represents a clear example of doctor shopping. This was a patient whose name is unknown, who was in her mid-eighties and who had been battling cancer for twenty-two years. Initially, two doctors, including her own physician who believed her request was due to depression, refused to prescribe her lethal drugs. Compassion & Choices in Oregon, then operating under the name Compassion in Dying, became involved in her case and referred the woman to a doctor willing to write the prescription.<sup>684</sup>
- 3.166. Evidence also exists that even in those rare instances where psychiatric referral occurs in Oregon, the psychiatric evaluation can be unreliable or insufficient as a result of doctor shopping:

*as N Gregory Hamilton MD pointed out, physicians who support assisted suicide will refer patients to psychiatrists or psychologists who agree with that view, and ‘the evaluations tend to be pro forma,’ or else alternative opinions that favour assisted suicide are found, providing no protection for people with depression and psychiatric disabilities.<sup>685</sup>*

### **Complications rates in Oregon**

- 3.167. The risks of complications are discussed in detail in Chapter 2 of this Report. The evidence from the Oregon Health Authorities own reports indicates that complications do arise and that patients seeking assisted suicide under the *Death With Dignity Act* (DWD Act) are not guaranteed a ‘good death.’

### **The requirement of ‘terminal illness’ is not strictly applied**

- 3.168. Oregon’s DWD Act requires that a person be certified by two physicians as suffering from a terminal illness before a lethal dose of medication can be lawfully prescribed. The annual report released in February 2017 shows that conditions that have been accepted as meeting this definition include benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson’s

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683 Pereira J (2011) ‘Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls,’ *Current Oncology* 18(2) 38-45 at 40.

684 ‘Some Oregon and Washington State Assisted Suicide Abuses and Complications,’ Disability Rights Education and Defense Fund <<https://dredf.org/public-policy/assisted-suicide/some-oregon-assisted-suicide-abuses-and-complications/>> and Golden and Zoanni (2010) ‘Killing Us Softly: The Dangers of Legalizing Assisted Suicide,’ *Disability and Health Journal* 3(1) 16-30 at 21.

685 Golden and Zoanni (2010) ‘Killing Us Softly: The Dangers of Legalizing Assisted Suicide,’ *Disability and Health Journal* 3(1) 16-30 at 24.

disease and Huntington’s disease), musculoskeletal and connective tissue diseases, viral hepatitis, diabetes mellitus, and alcoholic liver disease.<sup>686</sup> Earlier annual reports specifically mention some diseases that would not normally be classified as a terminal illness: myelodysplastic syndrome (not terminal unless it develops into acute myeloid leukemia, which itself is not necessarily terminal),<sup>687</sup> Hepatitis C,<sup>688</sup> and digestive organ neoplasm of unknown behaviour,<sup>689</sup> among others. It was suggested to the Committee that this evidence from the OHA reports reveals that the requirement that an illness be terminal is not being strictly applied in Oregon.<sup>690</sup>

- 3.169. Stahle and Randal also identify a significant problem with the requirement of a ‘terminal illness’ under the DWD Act. Under the Oregon Act, a person can be classed as being ‘incurably’ sick even when the disease can be treated! With treatment, these people would not be classed as ‘terminally ill’ but rather ‘chronically ill,’ thus all diseases which, without treatment, would be expected to result in death within six months are considered under the DWD Act to be ‘incurable’ and therefore qualify for assisted death. Consequently, a far greater number of patients can technically qualify for medically assisted suicide than just the extreme cases for which the law was originally said to apply.<sup>691</sup> Stahle was also given advice from the Oregon Health Authority that if ‘the patient cannot pay for the treatment, then the disease remains incurable.’<sup>692</sup>
- 3.170. The impact of this statement is evident in the cases of Barbara Wagner and Randy Stroup:

*The impact of the Oregon Health Plan’s drastic limitations became very real to Medicaid recipients Barbara Wagner and Randy Stroup. Wagner, a 64-year-old great-grandmother, had recurring lung cancer. Her physician prescribed Tarceva to extend her life. Studies show the drug provides a 30% increased survival rate for patients with advanced lung cancer, and patients’ 1-year survival rate increased by more than 45%.*

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686 Oregon Public Health Division (2017) ‘Oregon Death With Dignity Act: Data Summary 2016, Table 1. Characteristics and end-of-life care of 1,127 DWDA patients who have died from ingesting a lethal dose of medication as of January 23, 2016 [sic = 2017], by year,’ Oregon, 1998-2016 at 9 and 11, footnote 2, cited in Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 19.

687 Oregon Health Authority, Public Health Division (2003) *Fifth Annual Report on Oregon’s Death With Dignity Act* at 19.

688 Ibid at 21.

689 Ibid.

690 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 19.

691 Dwight Randal, President, Coalition for the Defence of Human Life, JSCEOLC Response to Questions on Notice, 17 April 2018 at 6.

692 Communication between Fabian Stahle and Craig New, Research Analyst, Oregon Health Authority, Center for Public Health Practice, Public Health Division, in December 2017 in the testimony of Julie Hocker, ACUF Senior Policy Fellow, and Senior Policy Fellow for the Centre for Human Dignity, to the New York Assembly Committee on Health, Public Hearing on Bill 2383-A, 3 May 2018 – referred to by Prof Somerville, Professor of Bioethics, University of Notre Dame Sydney, in Supplementary Information provided to the JSCEOLC, dated 8 May 2018.

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*But the Oregon Health Plan sent Wagner a letter saying the plan would not cover the beneficial chemotherapy treatment “but ... it would cover ... doctor-assisted suicide.” Stroup was prescribed mitoxantrone as chemotherapy for his prostate cancer. His oncologist said that while the drug may not extend a patient’s life by very long, it helps make those last months more bearable by decreasing pain. Yet Stroup also received a letter saying that the state would not cover his treatment but would pay for the cost of assisted suicide.<sup>693</sup>*

- 3.171. In the reasons for patient request for lethal medication under the DWD Act, patient concern about treatment costs has been recorded at 3.1 per cent (representing 30 reported cases in a studied cohort).<sup>694</sup> This evidence, and the cases of Wagner and Stroup, clearly evidence the real risk in Oregon that patients will be provided with lethal prescriptions in lieu of other more expensive medical treatments.

### **Lack of safety around patient-administered lethal drugs**

- 3.172. In 2016 either the prescribing physician (in 10.1 per cent of cases) or another healthcare provider (10.5 per cent) was known to be present at the time the lethal medication was ingested. For the remaining 79.4 per cent of people there was no physician or other healthcare provider known to be present at the time of ingestion.<sup>695</sup> Aside from the obvious issue around complications with the medication ingested without a medical professional present (already considered above), it was suggested to the Committee that in nearly four out of five cases in Oregon in 2016, ‘there is no independent evidence that the person took the lethal medication voluntarily. It may well have been administered to them by a family member or other person under duress, surreptitiously or violently. We can never know.’<sup>696</sup> Further, it was suggested that we cannot be sure that at the time the patient ingests the drug, which the reported data indicates may be up to two years after the prescription is provided, whether they have lost competency.<sup>697</sup>
- 3.173. The presence of a health care professional at the time of the patient ingesting the lethal medication has been reducing since the introduction of the legislation.<sup>698</sup> This reduction in the presence of a health care professional at the time of ingestion is associated with a significant reduction in safety for the patient.

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693 Golden and Zoanni (2010) ‘Killing Us Softly: The Dangers of Legalizing Assisted Suicide,’ *Disability and Health Journal* 3(1) 16-30 at 19.

694 Blank et al (2017) ‘Characterizing 18 Years of the Death With Dignity Act in Oregon,’ *JAMA Oncol* 3(10) 1403-1406.

695 Oregon Public Health Division, Oregon Death With Dignity Act: Data Summary 2016 at 7.

696 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 30.

697 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Transcript, 9 March 2018, Session 1 at 11.

698 Hedberg and New (2017) ‘Oregon’s Death With Dignity Act: 20 Years of Experience to Inform the Debate,’ *Ann Intern Med* 167, 579-583 at 582.



- 3.174. It is also worth noting at this point the introduction of Senate Bill 893 in Oregon to address the perceived shortcoming of Oregon's DWD Act where a person's disability may impede their assisted suicide. Brought to the attention of the Committee by Ms Re of Identity WA,<sup>699</sup> Bill 893:

*Permits expressly identified agent, pursuant to lawfully executed advance directive and in accordance with Oregon Death with Dignity Act, to collect and administer prescribed medication for purpose of ending patient's life in humane and dignified manner if patient ceases to be capable after having received prescription for life-ending medication.*

- 3.175. The passage of such a Bill would signal a further reduction in patient safety in Oregon.

### **The Oregon suicide rate**

- 3.176. Evidence was given to the Committee by Mr Francis of Dying for Choice, that there is no evidence of suicide contagion and that prior to the Oregon DWD Act, Oregon's suicide ranking amongst US states was worsening, while since the passage of the Act it has been improving.<sup>700</sup> Such an assertion is not supported by suicide statistics from Oregon:

*In 2012, the age-adjusted suicide rate among Oregonians was 17.7 per 100,000, 42 per cent higher than the national average. The rate of suicide among Oregonians has been increasing since 2000. Suicide rates among adults aged 45-64 years rose more than 50 per cent from 18.1 per 100,000 in 2000 to 28.7 per 100,000 in 2012, with the rate increasing more among females than among males.<sup>701</sup>*

- 3.177. Deaths relating to the DWD Act are not classified as suicides by Oregon law and are therefore not included in this data.<sup>702</sup> Earlier in this Report, when examining the Swiss model, it was noted that in evidence from Swiss assisted suicide provider Dignitas it was conceded that the suicide rate in Oregon has risen. In any event the sheer volume of suicides (both assisted and non-assisted) remain of great concern.

### **Palliative care in Oregon**

- 3.178. Research strongly suggests that Oregon has seen a reduction in the quality of end-of-life palliative care since the Oregon law went into effect. Dying patients in Oregon are nearly twice as likely to experience moderate or severe pain during the last week of life, as

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699 Ms Re, Chief Executive Officer, IdentityWA, JSCEOLC Response to Questions on Notice, 10 April 2018 at 2.

700 Mr Neil Francis, Dying for Choice, JSCEOLC Submission 642 at 43.

701 Shen and Millet (2015) *Suicides in Oregon: Trends and Associated Factors 2003-2012*, Oregon Health Authority, Portland, Oregon at 3.

702 Ibid at 7.

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reported by surviving relatives, compared with patients before the law took effect. Several recent studies show inadequate palliative and end-of-life care in Oregon.<sup>703</sup>

### **What happens when the law is violated in Oregon?**

- 3.179. Golden and Zoanni suggest that the death of Wendy Melcher in August 2005 illustrates the indirect impact of legalisation of assisted suicide on medical practice and law enforcement:

*Two nurses, Rebecca Cain and Diana Corson, gave Melcher large overdoses of morphine and phenobarbital. They claimed that she had requested assisted suicide, but they administered the drugs without her physician's knowledge, in clear violation of the law. Yet no criminal charges have been filed against the two nurses. Proponents of assisted suicide argue that this case has no connection to the Oregon law. But it is a strong indication of the legal erosion of public protections due to assisted suicide. The case prompted one newspaper to write, "If nurses or anyone else dare willing to go outside the law, then all the protections built into [Oregon's] Death with Dignity Act are for naught." Supporters of assisted suicide frequently assert, without evidence, that the underground practice of assisted suicide disappears where it is legal. But Melcher's death suggests the opposite, that underground assisted suicide probably does occur, and may in fact be thriving in Oregon in the wake of assisted suicide's legalization, due to the breakdown in legal rules and codes of conduct that elsewhere protect patients.<sup>704</sup>*

- 3.180. Annie O Jones, John Avery and three other patients are reported to have been killed by illegal overdoses of medication administered to them by a nurse, and none of these cases have been prosecuted in Oregon.<sup>705</sup>
- 3.181. Dr Katerina Hedberg of the Oregon Department of Human Services confirmed 'We are not given the resources to investigate [assisted suicide cases] and not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves.'<sup>706</sup>

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703 Golden and Zoanni (2010) 'Killing Us Softly: The Dangers of Legalizing Assisted Suicide,' *Disability and Health Journal* 3(1) 16-30 at 19, citing Fromme et al (2004) 'Increased family reports of pain or distress in dying Oregonians: 1996-2002,' *J Palliat Med* 7, 431-42 and Hendin and Foley (2008) 'Physician-assisted suicide: a medical perspective,' *Mich Law Rev* 106, 1613-40.

704 Golden and Zoanni (2010) 'Killing Us Softly: The Dangers of Legalizing Assisted Suicide,' *Disability and Health Journal* 3(1) 16-30 at 19.

705 Peter Korn 'Nursing chaos – Is Oregon State Board of Nursing Protecting Nurses at the Expense of Public Safety?' *Portland Tribune*, 6 March 2006.

706 Oregon Department of Human Services, News Release, 'No authority to investigate Death With Dignity case, DHS says,' 4 March 2005, quoted in 'Some Oregon and Washington State Assisted Suicide Abuses and Complications,' *Disability Rights Education and Defense Fund*

**Finding 105**

The law on assisted suicide in Oregon has been in force for 20 years and requires a prognosis of less than six months to live.

**Finding 106**

The data from the Oregon Public Health Division between 1998 and 2015 indicates that the longest recorded duration between initial request for assisted suicide and ingestion of the prescribed lethal drug was 1009 days.

**Finding 107**

The data from the Oregon Public Health Division in 2015 indicates that the longest recorded duration between initial request for assisted suicide and ingestion of the prescribed lethal drug was 517 days.

**Finding 108**

The data from the Oregon Public Health Division between 1998 and 2015 indicates that in 4 of the 17 years there was at least one case where the duration between initial request for assisted suicide and ingestion of the prescribed lethal drug was more than two years.

**Finding 109**

The experience in Oregon demonstrates the inadequacies of safeguards due to consistent medical error in prognosis.

**Finding 110**

In Oregon a 76-year-old cancer patient was assisted to suicide by his cancer specialist notwithstanding the presence of depression and the non-concurrence of the original doctor who referred the patient to the specialist for treatment.

**Finding 111**

In Oregon an octogenarian cancer patient was assisted to suicide notwithstanding that two doctors, including her own physician, were concerned about the presence of depression and refused to prescribe the lethal drug requested.

**Finding 112**

The experience in Oregon demonstrates the ease with which the prolific practice of doctor shopping pierces the veil of even well intentioned safeguards.

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<https://dredf.org/public-policy/assisted-suicide/some-oregon-assisted-suicide-abuses-and-complications/>

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### **Finding 113**

The data from the Oregon Public Health Division for 2016 indicates that in 79.4 per cent of assisted suicides no physician or healthcare provider was known to be present at the time of ingestion of the prescribed lethal drug.

### **Finding 114**

The rate of suicide among Oregonians has been increasing even when assisted suicides are excluded from the data set.

### **Finding 115**

The inherent difficulty in prosecuting after the event is underscored by at least five assisted suicides in Oregon that occurred by illegal overdoses administered by a nurse.

### **Finding 116**

The experience observed in Oregon should be reason alone to militate against legalisation in Western Australia.

### **Recommendation 18**

The Government and the Parliament of Western Australia should rule out introducing any assisted suicide regime based on the Oregonian experience.

## **The Gaping Hole—Issues with Reporting, Investigation, Prosecution and Redress**

- 3.182. Within the jurisdictions considered above, where assisted suicide has been legalised, there have been practitioners who have breached the framework established within those jurisdictions. This begs the question, how are such deaths to be investigated in Western Australia should assisted suicide also be legalised here?

### **A retrospective model of oversight**

- 3.183. Professors White and Willmott propose a retrospective model of oversight, and suggest that the value of reducing suffering is relevant to the question of the timing of the review of the decision-making:

*the value of reducing suffering points us towards a retrospective model rather than requiring further delay for the person who is in this intolerable state while yet another body be satisfied that he or she is eligible to receive assistance.*

...

*[A new retrospective body] removes questions or associations of unlawful or inappropriate behaviour... The body's functions could*

*include independent review of assisted dying cases (retrospectively), systems-level monitoring of the assisted dying regime (including the ability to make recommendations for systemic reform), and appropriate data collection and reporting.*<sup>707</sup>

- 3.184. Mr Mark Teale, Chief Executive of the Council on the Ageing WA (Inc), also saw value in establishing ‘an independent body to investigate any cases that are not on the surface as they appear they should be.’<sup>708</sup> He too suggested that the review conducted by this body should be retrospective in its operation.<sup>709</sup>
- 3.185. Mr Perron was also adamantly opposed to a review process prior to the assisted suicide of the patient like that recently adopted in Victoria, where the Victorian Civil and Administrative Tribunal has the power to review an application for assisted suicide while it is in process. This level of review was included in the Victorian legislation as a safeguard against doctor error or oversight, where there may be issues of competency and undue influence that had been overlooked at first instance. ‘Well, for goodness sake, let us have some thought for the patient,’ was Mr Perron’s response to such a safeguard.<sup>710</sup> ‘[A]nything that brings an external authority in to delay the process is undesirable.’<sup>711</sup>
- 3.186. The real risk of undue influence has been considered in depth in this Report in Chapter 2 and was raised with Mr Perron by Hon Nick Goiran in the Committee hearing:

*Hon NICK GOIRAN: Might a relative have a better understanding on whether somebody was under duress than a practitioner who meets the person for the first time in a brief consultation?*

*Mr PERRON: My answer simply is the patient’s view in these circumstances, being competent, being assessed as competent and being determined as they are to commit to this process, their view should prevail. Whether there was one or more relatives who were protesting most loudly, I believe should be of no consequence in delaying the process.*<sup>712</sup>

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707 Willmott and White (2017) ‘Assisted Dying in Australia: A Values-based Model for Reform,’ in *Tensions and Traumas in Health Law* at 508 and 509, submitted in Professors Willmott and White, Directors, Australian Centre for Health Law and Research and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, JSCEOLC Submission 560A.

708 Mr Teale, Chief Executive, Council on the Ageing WA (Inc), JSCEOLC Transcript, 2 March 2018, Session 5 at 5.

709 Ibid at 5-6.

710 Mr Marshall Perron, Private Citizen, JSCEOLC Transcript, 13 April 2018, Session 2 at 6.

711 Ibid at 7.

712 Ibid.

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- 3.187. Mr Perron’s response disregards the risk that undue influence presents to an individual seeking assisted suicide.
- 3.188. Even if a review model such as that adopted in Victoria were to be introduced here in Western Australia, such a review would only be conducted upon the application of a family member where the assessment process is believed by that person to have been compromised. Retrospective review of cases would still be necessary for all other cases.
- 3.189. In evidence given to the Committee, Professors White and Willmott favoured the establishment of a new retrospective body dedicated to overseeing an assisted suicide regime and did not favour oversight by the Coroner. They did not consider that deaths resulting from a practice that is recognised as lawful should be in the same category as ‘reportable deaths’ currently investigated by the Coroner, which they suggested sometimes includes connotations of these deaths being ‘suspicious.’<sup>713</sup>
- 3.190. This opinion directly conflicts with evidence given to the Committee by the Western Australian Coroner, the Commissioner of Police and the Director of Public Prosecutions, who all agreed that a full investigation of each assisted suicide case is warranted, including post-mortem examination.<sup>714</sup>
- 3.191. As will be demonstrated below, evidence was also provided to the Committee by each of these expert witnesses as to the difficulties currently experienced in Western Australia in relation to the investigation of suspicious deaths, which is relevant to consider before proceeding with the legalisation of assisted suicide in this State.

### **The self-reporting of doctors**

- 3.192. When asked by the Chair of the Committee as to how WA Police currently deal with reports that doctors have intentionally hastened the deaths of their patients the Commissioner of Police, Commissioner Chris Dawson replied that WA Police rarely receive such reports, however when such reports are received there is insufficient evidence to substantiate the criminal charge:

*One such matter that I have been briefed on was an allegation of a medical practitioner having administered a lethal injection. That investigation failed to identify sufficient evidence to substantiate the criminal charge. At the conclusion of that police investigation, which*

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713 Willmott and White (2017) ‘Assisted Dying in Australia: A Values-based Model for Reform,’ in *Tensions and Traumas in Health Law* at 509, submitted in Professors Willmott and White, Directors, Australian Centre for Health Law and Research and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, JSCEOLC Submission 560A.

714 Ms Fogliani, State Coroner of Western Australia, JSCEOLC Submission 537 at 1 and 2; and Miss Forrester, Director of Public Prosecutions and Mr Dawson, Commissioner of Police, JSCEOLC Transcript, 27 February 2018, Session 1 at 14.

*was in August 2016, we did refer the matter to the Health Practitioner Regulation Agency and provided information from that investigation.*<sup>715</sup>

3.193. WA Police are very much reliant on the matter being reported to them; if the next of kin of the patient or the doctor involved in the death do not report the case to WA Police, the case is not investigated.<sup>716</sup> Commissioner Dawson confirmed that in the case of legalised assisted suicide, if the medical authorities in charge of those patients did not report a suspicious death then it would be impossible for WA Police to scan institutions for all such deaths.<sup>717</sup>

3.194. The State Coroner of Western Australia, Ms Ros Fogliani, also confirmed in evidence to the Committee that she is reliant on suspicious deaths being reported to her office where a doctor's actions are believed to have hastened the death of a patient:

*we are not in the minds of the doctors. I am relying on people complying with their legal requirements, and their ethical duties as well if they are medical practitioners, to report a death to the coroner.*<sup>718</sup>

3.195. The self-reporting of doctors has been raised as a serious concern in jurisdictions where assisted suicide has been legalised.

3.196. In conflict with evidence given to the Committee by proponents that the law in Oregon 'has been working well with mandatory reporting and annual assessment by the Department of Health with no evidence of abuse,'<sup>719</sup> serious concerns have been raised about reporting requirements and practices in Oregon:

*The reporting requirement [in Oregon] lacks teeth. On paper, the law requires physicians to report all lethal drug prescriptions, but sets no penalties if physicians fail to report. Thus, this requirement is not enforced. Noncompliance is not monitored. The law requires annual statistical reports from the Oregon Public Health Division (OPHD), but OPHD does not monitor underreporting, noncompliance, or violations. Many of Oregon's reports acknowledge that the state cannot confirm compliance with the law. For example, OPHD announced in its first year that the state cannot determine if assisted suicide is practiced outside*

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715 Mr Dawson, Commissioner of Police, JSCEOLC Transcript, 27 February 2018, Session 1 at 9.

716 Ibid at 6.

717 Ibid.

718 Ms Fogliani, State Coroner of Western Australia, Coroner's Court of Western Australia, JSCEOLC Transcript, 1 March 2018, Session 1 at 16.

719 Dr Syme, Medical Practitioner and Vice President of Dying With Dignity Victoria, JSCEOLC Submission 316 at 5.

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*the law's framework, stating "[W]e cannot detect or collect data on issues of noncompliance with any accuracy."<sup>720</sup>*

...

*There is no investigation of abuse. The state has no resources or even authority to investigate violations, cases of expansion, and complications reported in the media or documented by others. There is no method for the public to report abuse. The Oregon Department of Human Services (DHS, of which OPHD is a part) acknowledged in a press release that DHS "has no authority to investigate individual Death with Dignity cases" [cited earlier in this Report] ...DHS further lacks the time and desire to investigate. As the years go by, it makes public less and less information. Secrecy pervades the operation of assisted suicide. There is an unnecessarily high level of secrecy about assisted suicide that undermines the public's right to know, as well as any independent, in-depth research. Oregon's law states "the information collected [for the annual reports] shall not be a public record and may not be made available for inspection by the public."<sup>721</sup> Moreover, as Hendin and Foley explained, the statute includes "no provision for an independent researcher or evaluator to study whatever data are available," and the lack of available data violates medical standards that "require openness about facts, research data, and records to assess the appropriateness of treatment."<sup>722</sup>*

*The underlying data are destroyed annually. Alarming, officials have acknowledged that OPHD destroys each year's records after it issues the report.<sup>723</sup>*

- 3.197. Issues with reporting were also raised by Blank et al in their recent study 'Characterizing 18 Years of the Death With Dignity Act in Oregon,' where they state that:

*The quality of our data is limited by the fact the attending physicians supplied the state with the underlying information... In addition, because the physicians attested to the patients' reasons for requesting*

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720 Oregon Public Health Division (1999) 'Oregon's Death With Dignity Act: the first year's experience,' Portland: Public Health Division.

721 Oregon Revised Statute 127.860 3.11.2.

722 Hendin and Foley (2008) 'Physician assisted suicide: a medical perspective,' *Michigan Law Review* 106 at 1613-40.

723 Golden and Zoanni (2010) 'Killing Us Softly: The Dangers of Legalizing Assisted Suicide,' *Disability and Health Journal* 3(1) 16-30 at 24 and 25, citing Hedberg K, 'Hearings Before the Select Comm. on the Assisted Dying for the Terminally Ill Bill of the House of Lords,' (9 December 2004) in House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill [HL] vol II: evidence (2005).



*[Death With Dignity] there is no way to ascertain whether the questioning of the patient was comprehensive.*<sup>724</sup>

- 3.198. Canada, the Netherlands and Belgium all have similar self-reporting requirements as those prescribed in Oregon. Aside from issues with the self-reported data as identified by Blank et al above, there is evidence that indicates that a substantial amount of assisted deaths are not reported at all. Studies show that more than 40 per cent of assisted deaths in Belgium were not reported at all in 2013, and that 23 per cent of assisted deaths in the Netherlands were not reported in 2015.<sup>725</sup>
- 3.199. Downie acknowledges that in all the jurisdictions where assisted suicide has been legalised, ‘nobody yet has developed a system that gathers reliable data on all requests (which can provide important evidence on a variety of issues such as patient access) or that facilitates research in an efficient, reliable, and cost-effective manner.’ In relation to reporting in Canada, she notes that ‘we are in a sense building the ship while sailing it and this is definitely not ideal.’<sup>726</sup>

#### **The best witness is dead**

- 3.200. In relation to investigating cases of elder abuse, Mr Michael Bowyer, Principal Legal Officer of the Public Trustee, gave evidence to the Select Committee on Elder Abuse on 26 March 2018, that ‘it is very difficult when your best witness cannot give evidence.’<sup>727</sup>
- 3.201. The unavailability of a witness in these cases was also identified by Western Australia’s Director of Public Prosecutions as an issue in evidence to the Committee. In relation to the prosecution of cases where it is alleged that a doctor has wrongly hastened the death of a patient, Miss Forrester states:

*in all of these cases the trouble is working out the facts. It is all well and good for allegations to be made, and part of the problem is that there is only one person left, usually, to tell what happened, and that is the person who is under investigation. That is a real problem for us.*

*If you have a situation where you have a doctor administering this treatment and the patient who says, “I want you to administer this treatment,” it depends on whether that is recorded and how it is*

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724 Blank et al (2017) ‘Characterizing 18 Years of the Death With Dignity Act in Oregon,’ *JAMA Oncol* 3(10) 1403-1406.

725 Chambaere et al (2015) ‘Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium,’ *N Engl JM* 372(12) 1179-81 and van der Heide et al (2017) ‘End-of-Life Decisions in the Netherlands Over 25 Years,’ *N Engl JM* 377, 492-94.

726 Downie J (2017) ‘Medical Assistance in Dying: Lessons for Australia from Canada,’ *QUT Law Review* 17(1) 127-146 at 144.

727 Mr Michael Bowyer, Principal Legal Officer, Office of the Public Trustee, Select Committee on Elder Abuse Transcript, 26 March 2018, Session 2 at 15.

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*recorded, but at the end of the day it is one person's say-so and that is the person administering the treatment. The patient, of course, is deceased.*<sup>728</sup>

- 3.202. This inherent challenge of this evidentiary issue was further unpacked in the following exchange:

*Miss FORRESTER: That is a problem we routinely encounter in these situations. The one person who says, "Well, that person wanted to die," is the person who is alleged to have killed them.*

*Hon NICK GOIRAN: What capacity is there for you to compel that person to give evidence?*

*Miss FORRESTER: Zero. The coroner has different capacities, but they could not be used in a criminal setting, obviously.*<sup>729</sup>

- 3.203. This evidence from the Director of Public Prosecutions clearly highlights that the self-reporting of the doctor, and the fact that the best witness is deceased, will mean that the investigation and prosecution of assisted suicide cases outside of the law will be effectively impossible.

### **What redress can be offered to the deceased patient?**

- 3.204. In relation to the recent Victorian legislation, Mr Denton submitted that 'If a breach [of the Victorian regulations by a medical practitioner] is detected, either doctor can be reported to the relevant authority, be that Victoria Police, the Coroner, or the Australian Health Practitioner Regulation Agency.'<sup>730</sup>
- 3.205. Aside from the inherent issues in detecting a breach that relies on self-reporting by the doctor and in the absence of the key witness, as discussed above, the question that then follows is: What remedy or redress does Mr Denton suggest would be available to the party wronged by a breach?
- 3.206. Mr Perron acknowledged that 'there is no redress for family or friends in the event that a death was hastened and one or more of the eligibility requirements was not met. Obviously one cannot be brought back from the dead.'<sup>731</sup>

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728 Miss Forrester, Director of Public Prosecutions, JSCEOLC Transcript, 27 February 2018, Session 1 at 11 (emphasis added).

729 Ibid (emphasis added).

730 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 41.

731 Mr Marshall Perron, Private Citizen, JSCEOLC Response to Questions on Notice, undated (emphasis added).

- 3.207. Associate Professor Blake of the University of Western Australia referred the Committee to the case of *Malette v Shulman*,<sup>732</sup> in which a blood transfusion was administered to a Jehovah's Witness patient who had not consented to that treatment. In relation to the redress offered to the patient in this instance, Associate Professor Blake noted that the patient can be compensated with a monetary payment, but '[the problem] is not fixed in the sense that it cannot put her in the position that she would have been in, but it is the way the law addresses those sorts of claims.'<sup>733</sup>
- 3.208. The distinction between a claim of wrongful life-sustaining treatment and one of wrongful assisted suicide is readily apparent. In the former the outcome of the treatment leaves a plaintiff or claimant capable of seeking redress. There is no capacity for a victim of a wrongful assisted suicide to seek redress. The wrongful act is not only irrevocable, but it also eliminates the person who has been wronged.
- 3.209. The irrevocable argument was one of the key arguments put forward for the abolition of the death penalty in Australia in 1955:

*The death penalty is irrevocable. Though the odds against an innocent person's being convicted of murder and hanged may be very great, the risk should never be taken. The death penalty is irreparable, and an irreparable judgement should never be pronounced except by an infallible tribunal. If an innocent person is hanged no redress is possible. Death admits of no compensation. Further, in executing the person, the mainspring of any movement to reverse the verdict is destroyed.*<sup>734</sup>

- 3.210. Professor Quinlan, Dean of the School of Law Sydney at the University of Notre Dame Australia, notes that the irrevocable argument in this context did not rely on evidence of the execution of the innocence for its force:

*Sheehan refers to no such case. He could not do so. Whilst some Parliamentarians referred to cases involving the inadvertent execution of innocent persons overseas, capital punishment was not abolished in Australia because there was a consensus that any innocent person had been executed in Australia. It was abolished for all—even those who had confessed to the most violent of murders or volunteered for capital*

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732 67 DLR (4th) 321, 72 OR (2d) 417.

733 Assoc Prof Blake, Legal Researcher, University of Western Australia, JSCEOLC Transcript, 26 February 2018, Session 3 at 14.

734 NSW Legislative Assembly, Crimes (Amendment) Bill Second Reading Speech, W.F. Sheehan, 23 March 1955 (3225) quoted in Quinlan M (2016) "'Such is Life': Euthanasia and capital punishment in Australia: consistency or contradiction?' *Solidarity: The Journal of Catholic Social Thought and Secular Ethics* 6(1) at 6.

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*punishment... The very small risk that an innocent person may be executed was considered unacceptable.*<sup>735</sup>

- 3.211. The irrevocable argument also prevailed in relation to capital punishment, despite infamous cases of recidivism. Professor Quinlan notes one of the most infamous cases of recidivism in Australia, that of artist Leonard Keith Lawson who was sentenced to death in May 1954 for tying up and raping three models. His sentence was commuted to life and, as he was an ideal prisoner, he was released in 1962. Within weeks of his release he had murdered a school mistress and a student.<sup>736</sup> Despite this case and others like it, where fear of recidivism was well founded, capital punishment was abolished in Australia.
- 3.212. Professor Quinlan notes that impact of the fear of recidivism can be seen in an opposite trend in relation to dangerous animals. Contrasts between the treatment of human beings and animals are regularly made by proponents of assisted suicide, for example, Mr Bob Dent, the first person to die in Australia under the ROTI Act, wrote in his final letter 'If I were to keep a pet animal in the same condition I am in, I would be prosecuted. If you disagree with voluntary euthanasia, then don't use it, but don't deny the right to me to use it.'<sup>737</sup> Elsewhere, in a 2013 interview with the BBC, Professor Stephen Hawking said 'I think those who have a terminal illness and are in great pain should have the right to choose to end their lives and those that help them should be free from prosecution. We don't let animals suffer, so why humans?'<sup>738</sup> In Australia, capital punishment of criminals for serious and violent crimes, even taking into account the recidivism of a criminal, has been prohibited. In contrast, legislation in every Australian jurisdiction allows for the destruction of dangerous dogs in the event of an unprovoked attack.<sup>739</sup> Professor Quinlan suggests that the reason that dangerous animals and dangerous humans are treated so differently under Australian law warrants further consideration.<sup>740</sup>

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735 Quinlan M (2016) "'Such is Life': Euthanasia and capital punishment in Australia: consistency or contradiction?" *Solidarity: The Journal of Catholic Social Thought and Secular Ethics* 6(1) at 6-7.

736 *Ibid* at 7.

737 Mr Bob Dent, quoted in Seth Mydans, 'Legal Euthanasia: Australia Faces a Grim Reality' *The New York Times*, 2 February 1997 <<https://www.nytimes.com/1997/02/02/world/legal-euthanasia-australia-faces-a-grim-reality.html>>

738 Prof Stephen Hawking, quoted in Sarah Boseley 'Professor Stephen Hawking backs right to die for the terminally ill,' *The Guardian*, 18 September 2013.

739 *Companion Animals Act 1998* (NSW) Pt 5, Div. 3, 4; *Animal Management (Cats and Dogs) Act 2008* (Qld) Ch 5 Pt 4; *Dog and Cat Management Act, 1995* (SA) s 51; *Dog Control Act 2000* (Tas) Pt 3, Div 4, 5; *Domestic Animals Act 1994* (Vic) Pt 7A, Divs 2, 6, s 84P; *Dog Act 1976* (WA) Pt 7; *Domestic Animals Act 2000* (ACT) Pt 2, Div 2.7 and see also Cao, Sharman and White, *Animal Law in Australia*, 184-186.

740 Quinlan M (2016) "'Such is Life': Euthanasia and capital punishment in Australia: consistency or contradiction?" *Solidarity: The Journal of Catholic Social Thought and Secular Ethics* 6(1) at 8.

- 3.213. Professor Quinlan suggests that the irrevocable argument, when applied to assisted suicide, would suggest that assisted suicide should remain prohibited if even a very small risk existed that a person's assisted suicide may have been carried out in error, or in circumstances beyond the eligibility criteria which the state specifies for permissible access to it:

*Whilst there were no definitive instances of innocent prisoners being executed, over the 196 year history of capital punishment in Australia, in the brief period in which euthanasia was lawful in the Northern Territory, 2 out of the 7 patients who sought euthanasia were provided with inadequate information of their true medical condition and of their treatment options.*

...

*Whilst some might argue that the irrevocable argument against euthanasia could be overcome in Australia through legislation with better safeguards and monitoring compliance, this defies the experience in the Northern Territory and other jurisdictions where euthanasia is lawful. If the safeguards provided in Australia's criminal justice system were not sufficient to overcome the irrevocable argument against capital punishment, it is very difficult to conceive of a euthanasia regime which could ensure that there was no risk of error.<sup>741</sup>*

- 3.214. The gaping hole in the proponents' argument that assisted suicide can be safely regulated is clear when issues around self-reporting, lack of witnesses and the irrevocable nature of assisted suicide are considered. Since investigation and prosecution present such a challenge, including in jurisdictions where assisted suicide is already legalised, together with the fact that there is no redress for the person who has been killed, the Parliament of Western Australia should rule out legalising assisted suicide in this State.

#### **Finding 117**

None of the jurisdictions where assisted suicide has been legalised have yet developed a system that gathers reliable data on all requests and instead rely on the self-reporting of doctors notwithstanding the inherent conflict of interest present.

#### **Finding 118**

Western Australia's Director of Public Prosecutions has no capacity to compel evidence from the sole surviving witness in an assisted suicide.

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741 Ibid at 7 and 12.

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### Finding 119

There is no capacity for a victim of a wrongful assisted suicide to seek redress.

### Finding 120

Capital punishment was abolished in Western Australia, notwithstanding the extensive safeguards in the State's criminal justice system, due to the risk that an innocent person may be executed.

### Finding 121

Authentic oversight of an assisted suicide regime is made difficult by a reliance on self-reporting and is made impossible by the unavailability of the best witness.

### Recommendation 19

The Government and the Parliament of Western Australia should rule out introducing any assisted suicide regime due to the known unresolved issues with reporting, investigation, prosecution and redress.

## Jurisdictions where Assisted Suicide Laws have Failed to Pass

- 3.215. The focus of the Committee has been on those jurisdictions where assisted suicide has been legalised, including Victoria, Oregon, Canada, the Netherlands, Switzerland and Belgium. No investigative travel was undertaken by the Committee to any of these jurisdictions.
- 3.216. The Committee's majority report has not assessed evidence from those jurisdictions that have rejected, and in some cases repeatedly rejected, assisted suicide laws.
- 3.217. Professor Somerville noted in evidence to the Committee that seven US States have approved physician-assisted suicide (and have rejected euthanasia), but that 17 States have expressly rejected assisted suicide.<sup>742</sup>
- 3.218. In contrast to the Canadian Supreme Court decision in *Carter*, so heavily relied upon in Committee evidence by the academic experts who were proponents of assisted suicide, the High Court of Ireland in *Fleming v Ireland & Ors* stated:

*In [Carter v Canada (AG)], the Canadian court reviewed the available evidence from other jurisdictions with liberalised legislation and concluded that there was no evidence of abuse. This Court also reviewed the same evidence and has drawn exactly the opposite conclusions. The medical literature documents specific examples of abuse which, even if exceptional, are nonetheless deeply disturbing. Moreover, contrary to*

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<sup>742</sup> Prof Somerville, Professor of Bioethics, University of Notre Dame Sydney, JSCEOLC Transcript, 1 May 2018, Session 8 at 2.

*the views of the Canadian court, there is evidence from this literature that certain groups (such as disabled neonates and disabled or demented elderly persons) are vulnerable to abuse. Above all, the fact that the number of LAWER ('life ending acts without explicit request') cases remains strikingly high in jurisdictions which have liberalised their law on assisted suicide (Switzerland, Netherlands and Belgium)—ranging from 0.4% to over 1% of all deaths in these jurisdictions according to the latest figures—without any obvious official response speaks for itself as to the risks involved.<sup>743</sup>*

3.219. The House of Lords in the United Kingdom concluded that:

*We do not think it possible to set secure limits on voluntary euthanasia... it would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were to be legalised. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused. Moreover to create an exception to the general prohibition of intentional killing would inevitably open the way to its further erosion whether by design, by inadvertence, or by the human tendency to test the limits of any regulation. These dangers are such that we believe that any decriminalisation of voluntary euthanasia would give rise to more, and more grave, problems than those it sought to address.<sup>744</sup>*

3.220. This decision has not been overturned in the United Kingdom, despite more than 10 attempts to introduce assisted suicide in that country since that time. As recently as 2015, a physician-assisted suicide bill was voted down in the United Kingdom, 330 votes to 118.

3.221. Between 1994 and 2017, a total of 231 bills to legalise assisted suicide have been introduced in the United States. Only seven of these bills have been successful. In 2017 alone, 43 bills were introduced in 26 states—all of which failed to pass.<sup>745</sup>

3.222. Assisted suicide legislation has also been unsuccessful introduced some 50 times by Australian legislatures since 1993.<sup>746</sup> Only two legislatures in Australia have passed

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743 [2013] IEHC 2 (emphasis added).

744 Report of the Select Committee on Medical Ethics, House of Lords, Vol 1, Session 1993-1994, 1994 London HMSO at 49, paragraph 238.

745 Alex Schadenberg, 'Assisted suicide legalisation defeated in the US in 2017,' 31 July 2017, citing the research of Dr Jacqueline H Abernathy, Tarleton State University.

746 Willmott, White, Stackpoole, Purser and McGee (2016) '(Failed) voluntary euthanasia law reform in Australia: Two decades of trends, models and politics,' *UNSW Law Journal* 39(1) 1 at 4, provided by Prof Willmott and Prof White, Directors, Australian Centre for Health Law Research, and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, in JSCEOLC Submission 560.

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assisted suicide laws in that time, being the Northern Territory (the operation of the *Rights of the Terminally Ill Act 1995* (NT) is considered in detail earlier in this Chapter) and the recent passage of the *Victorian Assisted Dying Bill 2017* (Vic) that has not yet come into effect. Notwithstanding this development, the AMA remains opposed to euthanasia and physician-assisted suicide.<sup>747</sup>

- 3.223. These statistics provide a proper context in which to consider the statements made by euthanasia proponents Dying With Dignity (WA) to the Committee that ‘euthanasia and physician-assisted suicide are increasingly being legalised’ and that ‘the number of jurisdictions around the world providing assisted dying is growing steadily.’<sup>748</sup>
- 3.224. In fact, in the first half of 2018 assisted suicide legislation has already been rejected in Finland,<sup>749</sup> Guernsey,<sup>750</sup> and Portugal.<sup>751</sup>
- 3.225. In a ruling passed down in June this year the UK Court of Appeal rejected the argument brought by Mr Noel Conway that the current blanket ban on assisted suicide under the *Suicide Act* is incompatible with his human rights.<sup>752</sup>
- 3.226. Mr Antonio Filipe, Member of the Portuguese Parliament, explained that the Communist Party in Portugal saw euthanasia:

*not as a sign of progress but a step towards civilizational regression with profound social, behavioural and ethical implications.*

*In a context in which the value of human life is frequently made conditional on criteria of social utility, economic interest, family responsibilities and burdens or public spending, legalisation of early death would add a new dimension of problems.*

*First of all accelerating the deaths of those to whom society refuses to respond and support in situations of fragility and need. Faced with*

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747 Dr Khorshid, President, AMA(WA), JSCEOLC Transcript 18 May 2018, Session 1 at 5.

748 Dying with Dignity (WA), JSCEOLC Submission 565, at 15 and 24.

749 A citizens’ initiative on ‘active death help,’ or euthanasia, was overwhelmingly rejected by the Finnish Parliament by a vote of 128 to 60 in May 2018: ‘Riksdagen går inte vidare med att legalisera eutanasi – rösterna föll 128–60,’ Hufvudstadsbladet, 4 May 2018.

750 In May 2018, a requete, similar to a private member’s bill, was voted down 24 votes to 14 in Guernsey: Sarah Knaption, ‘Guernsey rejects assisted dying after three day debate,’ *The Telegraph*, 18 May 2018.

751 A euthanasia bill drafted by the ruling Socialist party in Portugal was defeated in May 2018, 115 votes to 110. The Communist party, usually a strong ally of the ruling Socialist party, joined the conservative CDS People’s Party in voting against the euthanasia bill: Andrei Khalip, ‘Portugal parliament rejects legal euthanasia in divisive vote,’ *Reuters*, 30 May 2018.

752 *Noel Douglas Conway v The Secretary of State for Justice* [2017] EWCA Civ 16; see Lizzie Dearden, ‘Terminally ill man loses latest round of legal battle against UK’s ban on assisted dying,’ *The Independent*, 27 June 2018



*human suffering, the solution is not to divest society of responsibility by promoting early death but to ensure conditions for a dignified life.*<sup>753</sup>

- 3.227. It is clear that ‘The relief of suffering, loneliness and helplessness in the terminally ill is one of the major challenges facing our society in general and the health care professions in particular.’<sup>754</sup> However, as Antonio Filipe asserts, assisted suicide is not the solution. Western Australia should follow the lead of Portugal, and countless other jurisdictions both here in Australia and around the world, who have refused to promote early death and have not decriminalised assisted suicide. Instead, efforts should be made by the government of Western Australia to ensure conditions for a dignified life for all Western Australians.

## **The Victorian Model and Logical Incremental Extension**

### **Heavy Criticisms of the Victorian legislation by Proponents of Assisted Suicide**

- 3.228. Unlike the Northern Territory experience, the Victorian experience is not a lived experience. This was noted by Clinical Professor David Forbes, Acting Chief Medical Officer of the Department of Health, Western Australia. When asked about the implications and impact in Victoria of the *Voluntary Assisted Dying Bill 2017* (Vic), Professor Forbes gave evidence to the Committee that, from discussion with his colleagues in Victoria, ‘My impression is that they do not know what they do not know, having legislated. There are a lot of complex issues about management of people that are still to be resolved that legislation does not solve.’<sup>755</sup>
- 3.229. Concern was raised from a medico-legal perspective about the management of Schedule 8 drugs in the community under the Victorian model, where, like the practice in Oregon, ‘a drug that is potentially even more lethal than many drugs on [the Schedule 8 list] ...may just be placed into the hands of an individual to then take back to their home and possibly administer... so then we are left with what is potentially a very lethal drug being out in the community.’<sup>756</sup>
- 3.230. In addition, before the legislation has even come into force, it has been the subject of significant criticism by many assisted suicide proponents.
- 3.231. Dr Sinclair of the University of Western Australia criticised the *Voluntary Assisted Dying Act 2017* (Vic) as being too narrowly framed. It is his view that the Victorian framework for eligibility, which requires people to have a life-limiting illness with a life expectancy

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753 ‘Portugal votes against decriminalising euthanasia,’ 31 May 2018

<<https://morningstaronline.co.uk/article/portugal-votes-against-decriminalising-euthanasia>>

754 Zalcberg JR and Buchanan JD (1997) ‘Clinical issues in euthanasia,’ *MJA* 166 150 at 151.

755 Prof Forbes, Acting Chief Medical Officer, Department of Health, JSCEOLC Transcript, Session 2, 18 May 2018 at 45.

756 Mrs Greenwood, Chief Executive, Catholic Health Australia, JSCEOLC Transcript, 28 February 2018, Session 1 at 15.

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of less than six months, or 12 months in the case of it being a progressive neurological condition, is too narrow. Also said to be too narrow is the requirement that the patient have full legal capacity to execute their own decisions. Dr Sinclair was critical that advance directives for assisted suicide were also explicitly not permitted within this legislation.<sup>757</sup> Dr Sinclair elaborates:

*As Professor Kathy Eagar commented in relation to the Victorian legislation, it is very narrow in scope and incorrectly frames the matter as a health issue, rather than a social issue. Perhaps this strategy might have been taken as a political compromise, but she also argues that it sidesteps the difficult debate about the real reasons why people choose assisted dying—that it is more often about wanting to maintain independence and control, rather than avoiding severe pain at the end of life. That is what we see from the empirical evidence from people who actually request and follow through on a request for assisted dying.*<sup>758</sup>

- 3.232. In their submission to the Committee, Dr Sinclair and Associate Professor Blake argue that the Victorian model is too narrow in its scope in that it can only be accessed by those with a terminal illness who are expected to die within a year. They suggest that setting time limitations is not useful or practical, and that access should not be limited only to those with a terminal illness, but that other chronic conditions should also be included.<sup>759</sup>
- 3.233. Like Dr Sinclair and Associate Professor Blake, Professors White and Willmott were also critical of the inclusion of time frames or time limits in assisted suicide legislation:

*First, the balancing of values... does not point to the need for a specified period of time. Secondly, it is difficult to predict with any certainty when a person is likely to die, making the eligibility certification a challenging if not impossible task for the doctor. Thirdly, a practical harm that can occur when temporal limits are imposed is that people who have a relevant medical condition that will cause their death but are outside the relevant time period may choose to starve themselves until they are close enough to death that the time condition is satisfied.*<sup>760</sup>

- 3.234. The Professors suggest that the removal of a time limit to require a particular proximity to death would enable people with fatal illnesses such as cancer, motor neurone disease

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757 Dr Sinclair, Research Fellow, University of Western Australia, JSCEOLC Transcript, 26 February 2018, Session 3 at 11.

758 Ibid.

759 Assoc Prof Blake and Dr Sinclair, University of Western Australia, JSCEOLC Submission 584 at 9.

760 Willmott and White (2017) 'Assisted Dying in Australia: A Values-based Model for Reform,' *Tensions and Traumas in Health Law* at 503-4, submitted in Professors Willmott and White, Directors, Australian Centre for Health Law and Research and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, JSCEOLC Submission 560A.

and dementia (provided he or she retains capacity) to obtain assistance to suicide, and would also include a person with a medical condition such as quadriplegia who required artificial nutrition and hydration to survive.<sup>761</sup>

- 3.235. Dr Lancée also gave evidence to the Committee that the Victorian legislation was too ‘bureaucratic:’

*The group Doctors for Assisted Dying Choices is preparing a review of the Victorian Act, which has 142 sections and 130 pages. This compares to the 12 pages of the Oregon Act. The group Doctors for Assisted Dying Choice is very keen to see a simplified less bureaucratic bill for Western Australia.*<sup>762</sup>

- 3.236. The 68 criteria in the Victorian bill were considered by Dr Lancée to be ‘excessive and create needless barriers to the most vulnerable, the terminally ill.’<sup>763</sup>
- 3.237. Mr Perron gave evidence that ‘[t]he Victorian bill has unfortunately been drafted with a view to minute control of the process at every stage and that has made it overly bureaucratic and unnecessarily expensive.’<sup>764</sup>
- 3.238. Dr Nitschke considered the Victorian legislation to be ‘so safe as to be almost unworkable.’ He stated ‘I have indicated that I believe the Victorian law, which will come in next year, is probably the world’s most unworkable piece of legislation.’<sup>765</sup>

### **Political pragmatism**

- 3.239. In direct contrast with those criticisms made of the Victorian legislation above, Mr Denton was supportive of the Victorian Act. Reassuring the Committee that the Victorian Act will not open the floodgates to assisted suicide on demand, Mr Denton states:

*Surrounding this framework and these principles and conditions is a complex administrative structure involving 68 safeguards. It will not be an easy matter to obtain assistance to die. Nor for a doctor to sign off on it.*<sup>766</sup>

- 3.240. And:

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761 Ibid at 504.

762 Dr Lancée, Medical Practitioner, JSCEOLC Transcript, 5 April 2018, Session 6 at 7.

763 Dr Lancée, Medical Practitioner, Doctors for Assisted Dying Choice, JSCEOLC Transcript, 2 March 2018, Session 3 at 2.

764 Mr Marshall Perron, Private Citizen, JSCEOLC Submission 23 at 6.

765 Dr Nitschke, Exit International, JSCEOLC Transcript, 13 April 2018, Session 1 at 2.

766 Mr Denton, Go Gentle Australia, JSCEOLC Submission 539 at 40.

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*Of the small number of dying persons who will consider the option of VAD [voluntary assisted dying] (as many do now) only a tiny majority will satisfy its strict eligibility criteria.<sup>767</sup>*

3.241. These assurances from the non-medically and non-legally qualified witness are curious in light of his stated concern for the ‘5% of souls beyond the help of palliative care who suffer so terribly as they die.’<sup>768</sup> To applaud a regime that will not be accessible by all those said to be in need of the regime seems, at best, counterintuitive.

3.242. Mr Denton’s reassurance to the Committee in his submission is also hollow when considered in the light of comments made during his hearing that:

*Part of the reason I think [the Victorian legislation] is superior is that it has become law. I think part of the issue and problem with this debate over 20 years is that there have been attempts to pass a very wide piece of legislation through a very narrow political reality.<sup>769</sup>*

3.243. In Mr Denton’s opinion it is not that the Victorian legislation is particularly safe, or workable, that makes it superior to other legislative models and warrants consideration by the Parliament of Western Australia, but that it was simply narrow enough to get through Parliament in the first place.

3.244. That assisted suicide legislation comes down to what is politically pragmatic is further illustrated in this comment by Mr Denton, with regard to the assisted suicide of the elderly and those without a terminal illness:

*I deeply understand this. I think there are many older people who do not have what we call a terminal disease who have so many different illnesses and ailments that their life is absolutely miserable. Their life is full of suffering. I deeply understand that. I know in the Netherlands and Belgium that under their law, which is very differently framed to other places, which refers to unbearable or unendurable suffering, that they do allow cases of people with multiple ailments but not necessarily a terminal disease. Personally, I think that is a humane thing to do but I think politically in Australia, it is probably not an acceptable thing to do... [Dr Nitschke] would argue that, “But you are just actually not sectioning off a particular group of the community.” In some ways, that is true, but that is because I believe, as I said before, that there is a political reality in this country. We have to write laws that suit our society and that suit our medical profession. So I understand where that*

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767 Ibid at 38.

768 Ibid at 7.

769 Mr Denton, Go Gentle Australia, JSCEOLC Transcript, 13 April 2018, Session 6 at 4.

*desire comes from but it is my belief that it is not a political reality in this country at this time.*<sup>770</sup>

- 3.245. Evidence of political pragmatism is seen in this exchange between Committee member Hon Dr Sally Talbot and Mr Francis, assisted suicide proponent:

*Hon Dr SALLY TALBOT: Mr Francis, can I explore with you a bit further the question of who is included in the provisions. You mentioned the difficulty presented, for example, by the Victorian legislation for people with motor neurone disease. The committee is familiar with that statistical evidence that people with cancer will often have quite a high quality of life until relatively shortly before they die whereas people with other sorts of diseases, particularly neurodegenerative diseases, will have a rapid decline fairly early on. One of the things that has interested me about watching the Victorian process is a concern about people with dementia and the various forms of dementia, not just Alzheimer's, so the movement-related dementias associated with Parkinsonism, your Parkinson-type diseases. Do we need to include people with those diseases in this kind of legislation? I will just start with that broad question.*

*Mr FRANCIS: Thank you, Dr Talbot. That is an excellent question. I would preface my remarks by saying include in a bill those provisions that are likely to enjoy the support of the majority of members on the floor of the house, politics being the art of the possible. It would be wise to consult members as to what their views were.*<sup>771</sup>

- 3.246. Despite criticising the Northern Territory ROTI Act as containing too many safeguards that were difficult to work with, Dr Nitschke states that 'I suppose people learnt from that, in particular people seeking legislative change, that there needs to be perhaps even tougher laws so that they actually pass the parliamentary process.'<sup>772</sup>

- 3.247. In reference to the Victorian legislation, Mr Perron gave evidence to the Committee that in order to get it through parliament:

*they have made it, as the Premier has declared, probably the most conservative legislation in the world. I am not sure that that is a thinking*

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770 Ibid at 11.

771 Mr Neil Francis, Dying for Choice, JSCEOLC Transcript, 9 April 2018, Session 1 at 17 (emphasis added).

772 Dr Nitschke, Exit International, JSCEOLC Transcript, 13 April 2018, Session1 at 2 (emphasis added).

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*we should be so proud of, but at least we have legislation. I understand in politics it is the art of the possible.*<sup>773</sup>

- 3.248. In discussing his *Voluntary Euthanasia Bill 2009* (WA) in a Western Australian Voluntary Euthanasia Society Newsletter, Hon Robin Chapple MLC also identified the need for political pragmatism in first getting a restrictive piece of legislation passed so that extension can follow:

*I realise this is a very restrictive Bill. However, it was my intention to draft a restrictive Bill. This is because a restrictive law has the best chance of being passed by the current Western Australian Parliament. I know many readers will be disappointed that this Bill does not go further, does not apply to more people and does not allow for administration of euthanasia by a person other than a medical practitioner. But this law is a good start, and a step in the right direction.*<sup>774</sup>

### **One person's safeguard is another person's obstacle**

- 3.249. Proponents of assisted suicide encouraged the Committee to consider whether safeguards are really necessary since the protection of patients from abuse can be achieved 'without subjecting ill people to a protracted bureaucratic process in an already stressful and likely painful situation.'<sup>775</sup> Mr Francis advised 'what I would encourage you to do is to think actively about how precious we are going to be about a gazillion criteria in relation to a physician-assisted death.'<sup>776</sup> Meanwhile Dying With Dignity's submission recommended that 'such limitations should be confined to those that are reasonably necessary to ensure that the individual's wishes regarding their end of life are given primacy.'<sup>777</sup>
- 3.250. In his book *Angels of Death: exploring the euthanasia underground*, Magnusson notes that 'For some, safeguards are an obstacle to patient autonomy, an invitation for 'compassionate totalitarians' to dominate weak and frail patients at the very time they most need to have their autonomy respected' and 'The stricter the process for screening out wrong reasons, however, the more difficult it becomes for patients to have their 'right' reasons vindicated.'<sup>778</sup>

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773 Mr Marshall Perron, Private Citizen, JSCEOLC Transcript, 13 April 2018, Session 2 at 5 (emphasis added).

774 Hon Robin Chapple discussing his *Voluntary Euthanasia Bill 2009*, quoted in *WAVES News*, Vol 30, Issue 1, February 2010 (emphasis added).

775 Exit International (WA), JSCEOLC Submission 100 at 2.

776 Mr Neil Francis, Dying for Choice, JSCEOLC Transcript, 9 April 2018, Session 1 at 11.

777 Dying with Dignity (WA), JSCEOLC Submission 565, at 3.

778 Magnusson RS (2002) *Angels of death: exploring the euthanasia underground* at 252 and 253.

- 3.251. Dr Nitschke was highly critical of the safeguards written into the ROTI Act, suggesting that they made very sick people ‘jump through hoops’ and in his experience were not workable in practice:

*Of course, what we got in that piece of legislation, that Rights of the Terminally Ill Act, was a piece of legislation that made very sick people jump through hoops. When the law passed, I found myself dragging very sick people—in the first case, Bob Dent—from doctor to doctor to get the signatures necessary to demonstrate eligibility to die. The irony of that was not missed on people like Bob Dent who was so sick, yet he said, “I have to qualify to be eligible to die.” I felt cruel having to drag him around to make him satisfy those onerous restrictions of that law. I saw the need for safeguards, but they were particularly difficult ones to comply with.<sup>779</sup>*

- 3.252. In discussing the Canadian experience, Downie argues that criteria for access and procedural safeguards have had negative consequences and have caused suffering and that safeguards (such as capacity required at the time of provision, mandatory waiting periods, access limited to those for whom death is ‘reasonably foreseeable’ and allowing providers and institutions to opt out) must be avoided:

*beware of negative consequences that can accompany particular turns of phrase in legislative drafting and particular positions taken on substantive issues in the debate about criteria for access and procedural safeguards. In particular, as illustrated earlier, there are serious negative consequences flowing from the following elements of the Canadian legislation: capacity required at time of provision; mandatory waiting periods; access limited to those for whom death is ‘reasonably foreseeable’; and allowing providers and institutions to opt out. This is not to say that legislators must avoid all of these elements (although I would argue for that). Rather, it is to say that legislators must be aware of the consequences of proceeding with those elements. It might be argued that the Canadian government did not know and therefore should not be blamed for the consequences of their legislative drafting. However, any jurisdiction that follows Canada will have been forewarned and will therefore bear the responsibility for the suffering that ensues.<sup>780</sup>*

- 3.253. Dying with Dignity also note restrictions ‘imposed by society’ based on a terminal prognosis timeframe, like those contained in the Victorian legislation and recommended

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779 Dr Nitschke, Exit International, JSCEOLC Transcript, 13 April 2018, Session 1 at 2.

780 Downie J (2017) ‘Medical Assistance in Dying: Lessons for Australia from Canada,’ *QUT Law Review* 17(1) 127-146 at 144-5.

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by Mr Denton, are ‘cruelly drawn’ and ‘arbitrary’ categories that should be minimised and that maximal weight should be attached to the right of a rational and informed person to make their own choices.<sup>781</sup>

### **Arbitrary eligibility criteria and discrimination**

- 3.254. Professors White and Willmott note that a key principle of the rule of law identified by the Law Council of Australia is that ‘the law should be applied to all people equally and should not discriminate between people on arbitrary and irrational grounds.’<sup>782</sup>
- 3.255. The Professors suggest that there is a right to assistance to die that applies under certain prescribed and limited conditions. However, as Carr correctly asserts, ‘Once you introduce rights to one group of people, it is a political inevitability that others will soon demand to have those rights extended to them in the name of equality. Anything less than this incremental extension of rights is surely discrimination, is it not?’<sup>783</sup>
- 3.256. The issue of rights discrimination was also identified by former Attorney General Hon Michael Mischin MLC in parliamentary debate about the establishment of the Joint Select Committee on End of Life Choices and the terms of reference of the Committee:

*If we are talking about a fundamental right to choose to end one’s life and to get assistance to achieve that end, why should it be under any constraint from any legislation? It is either a right or it is not. If it is a right that should be granted to people—if it is to be allowed, if you like, forgetting about the terminology or detail about how it is done—and if it is such a fundamental right for someone subject to a chronic and painful illness that is untreatable and unbearable, why should it be limited to any time limit before that? Why should it be limited at all to terminal, chronic illnesses when the pain is unbearable and untreatable? Surely, if someone has a lifetime of chronic pain that is unbearable and incapable of relief ahead of them, I would have thought that having a time limit is less persuading as to why someone should be allowed to kill themselves with assistance than being able to kill themselves well in advance. Why should it be limited to physical pain and not mental anguish? Why should it be limited to adults of sound mind? Should there be some kind of assistance from, perhaps, experts*

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781 Dying with Dignity (WA), JSCEOLC Submission 565 at 18.

782 Willmott and White (2017) ‘Assisted Dying in Australia: A Values-based Model for Reform’ *Tensions and Traumas in Health Law* at 495, submitted in Professors Willmott and White, Directors, Australian Centre for Health Law and Research and Ms Neller, Centre Coordinator, Australian Centre for Health Law Research, JSCEOLC Submission 560A.

783 Carr L (2017) ‘“It’s about people like me”: disabled and dead against euthanasia,’ <<https://www.mercatornet.com/careful/view/its-about-people-like-me-disabled-and-dead-againsteuthanasia/20276>> quoted in Rev Dr Parkinson, LJ Goody Bioethics Centres, JSCEOLC Submission 53 at 7.



*to make these decisions for others who are incapable of making those decisions themselves? Where do we cross the line between doctors being the ones who we can entrust with the responsibility of saving our lives to the ones who will counsel, "You are going to die anyway. Let me try to relieve your pain by helping you kill yourself"?*

...

*If there is such a right, I hope that no constraints will be put on the exercise of that right because only then is it a proper right. If it should be, as Hon Alannah MacTiernan has told us, that people ought to decide when to draw the line under their own lives, why should it be limited in the way that has been hinted at? Those are some of the things that I hope this committee will explore and do so robustly and not with any preconceived wishy-washy idea of limiting this to specific circumstances, knowing that someone will fall beyond those particular lines that will be arbitrarily drawn and having to extend them from time to time as time goes on.<sup>784</sup>*

- 3.257. That exclusionary criteria are considered to be discriminatory by proponents of assisted suicide is illustrated by the evidence given to the Committee by Dr Syme about the exclusion of children from assisted dying laws:

*I do believe that there is a very reasonable place for allowing children under 18 who have got the mental capacity to make these decisions, that that could be allowed, but in saying that, I do acknowledge that politics is the art of the possible and all of you politicians face the difficult issue of reaching a piece of legislation which will be acceptable to everybody.*

...

*I do believe that not extending the legislation to children of mature age and capacity can be discriminatory.<sup>785</sup>*

- 3.258. Dr Syme goes on to suggest that although the Victorian legislation was pragmatically restrictive in order to get passed by Parliament, it is discriminatory in its operation:

*But the simple medical fact is that if suffering is the reason why people request assistance to die, not how long they have got left to live, then suffering is not confined to people with a particular period of time to*

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784 Hon Michael Mischin, *Hansard*, Legislative Council, 22 August 2017 at 3100 – 3101.

785 Dr Syme, Medical Practitioner and Vice President of Dying with Dignity Victoria, JSCEOLC Transcript, 13 April 2018, Session 4 at 3 and 4 (emphasis added).

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*live. As I have tried to indicate to you, there are a number of people who will be going to die in a lot longer than six months, but they have intolerable suffering. But, again, you come back to the political question: What is acceptable to you people as politicians? What is possible to be passed as legislation? The Victorian committee and the Victorian Parliament accepted that for legislation to be accepted by the community and by the politicians, there had to be a limitation, and it was accepted that the legislation in Oregon of six months was to be the model. I do not disagree with the fact that that is a reasonable model, but I will make the point that it is discriminatory against some people with some illnesses who will have grievous suffering who will not qualify under that legislation.*<sup>786</sup>

- 3.259. Ironically, in discussing a patient who suffered from a mental illness and who sought his assistance to die in his book *A Good Death*, Dr Syme acknowledges that ‘The reality is that it is not possible to solve, or even begin to solve, everybody’s problems.’<sup>787</sup> This begs the question on what basis can lawmakers discriminate in drawing criteria around access to assisted suicide?
- 3.260. Dr Michael Gannon, President of the AMA (as he was at the time), in discussing the assisted suicide of Dr Goodall in Switzerland, said ‘I have serious concerns about a community where we make arbitrary decisions about whose life is valuable enough to continue and whose should be ended under the law.’<sup>788</sup>
- 3.261. As Mr Byl, who gave evidence to the Committee about his own experience living with a disability, states:

*It is only logical that if euthanasia is legalised with, of course, safeguards in place, that these safeguards will be challenged. Equality and anti-discrimination demand that they be challenged. Euthanasia with safeguards means a select few will be allowed to die. They are on the right side of the barrier, so to speak. But what are you going to say to the guy on the other side of the barrier or, in fact, even up against it? Are you going to say, “Sorry, mate. Your life isn’t tough enough. You’re not enough of a burden. You’ll have to keep living?”*<sup>789</sup>

- 3.262. Any restriction on eligibility is an arbitrary one and is discriminatory.

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786 Ibid at 5-6.

787 Syme R (2008) *A good death: An argument for voluntary euthanasia* at 218.

788 Dr Gannon quoted by Philip Oltermann in ‘David Goodall, Australia’s oldest scientist, ends his own life aged 104,’ *The Guardian*, 10 May 2018.

789 Mr Byl, Private Citizen, JSCEOLC Transcript, 1 May 2018, Session 6 at 2.

**Restrictive legislation will be amended through logical incremental extension**

- 3.263. The Committee received evidence that during the legislative proposal phase the focus is almost universally on an alleged group of hard cases, small in number, who, it is said, are suffering from unbearable physical pain or other physical symptoms that cannot be relieved by even the best palliative care. After implementation, however, it becomes clear that the real focus is on autonomy, an alleged right to assistance to die, the application of which is extended to more and more categories of suffering.<sup>790</sup>
- 3.264. Proponents of assisted suicide were very aware of the need to endeavour to distance themselves from any ‘slippery slope’ argument:

*Mr WOOD: I think that in an ideal situation—and it is not a slippery slope-type argument—as time goes by, the act will be reviewed with a view to saying, “Well, what problems have we got here? Can we solve them?” and go from there.<sup>791</sup>*

...

*Mr WOOD: ...I think we should start small, possibly start with a very tight bill, and, as society progresses and the demand and the logic is there to expand slightly, well then that is the prerogative of Parliament.*

*Hon NICK GOIRAN: So, Mr Wood, you are a supporter of the slippery slope, then?*

*Mr WOOD: That is not the slippery slope.*

*Hon NICK GOIRAN: You would like to describe it in some other fashion?*

*Mr WOOD: I think there is a difference between a slippery slope, which is where somebody alleges that a progression from one state to another is inevitable.*

*Hon NICK GOIRAN: Right, because I thought I just heard you say that we should start small and then continue to progress.*

*Hon Dr SALLY TALBOT: That is not a slippery slope.*

*Mr WOOD: If society suggests and the Parliament agrees that we should have it available in a wider form.*

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790 Mr Egan, Research Officer, Defend Human Life!, JSCEOLC Submission 5 at 1.

791 Mr Wood, Christians Supporting Choice for Voluntary Euthanasia, JSCEOLC Transcript, 13 April 2018, Session 3 at 4.

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*Hon Dr SALLY TALBOT: The slippery slope is actually a technical definition of the way of arguing that is false. Mr Wood is exactly right.*

*Hon NICK GOIRAN: I am intrigued by the distinction that is being drawn by both Mr Wood and my colleague.<sup>792</sup>*

- 3.265. Mr Luley of Dignitas described this logical incremental extension in the following way:

*What you have, of course, and that is a development in society—when you have new needs for society coming, then you might have the situation that some people say, “Thank you for this law which gives, let us say, terminally ill people with six months’ life expectancy the possibility for end-of-life choice,” but then after 10, 20 years, you might have a development in society that people want more freedom of choice. Then they might call for, “Let’s extend that to 12 months.” That is not a slippery slope. That is a development in society where people want to have more freedom of choice. I think that our opponents mix that up to make an argument against even freedom of choice.<sup>793</sup>*

- 3.266. Dr Nitschke also gave evidence to the Committee that in adopting ‘an extremely safe piece of legislation with many safeguards,’ Western Australia may in fact:

*end up with a model that really does not serve the interests of people who are seeking help to die. You can see some of these problems because when you start trying to codify—that is, set up the conditions under which a person can get help to die, and make those conditions very, very clear and strict—then of course there will be argument about whether or not people qualify... What qualifies? Do you have to be terminal? What is wrong with chronic suffering as a reason for wanting to die?<sup>794</sup>*

- 3.267. Dr Nitschke continues:

*What has happened where we have seen laws change... such as places like Holland, where I am now a resident, is that over the years people realised that the onerous restrictions cause difficulty and, of course, there is an erosion or a change to those requirements. We have seen changes here, first of all, to the age of eligibility, and then the nature of the condition and the nature of suffering that entitles a victim to make*

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792 Mr Wood, Christians Supporting Choice for Voluntary Euthanasia, Hon Dr Sally Talbot, Hon Nick Goiran, JSCEOLC Transcript, 13 April 2018, Session 3 at 6-7.

793 Mr Luley, Board member, Dignitas, Switzerland, JSCEOLC Transcript, 9 April 2018, Session 2 at 3 (emphasis added).

794 Dr Nitschke, Exit International, JSCEOLC Transcript, 13 April 2018, Session 1 at 2.

*use of these laws. The rest of the world says, "That's an example of the slippery slope, the fact that we are seeing populations say, 'These laws don't really serve what people want.'" I think, quite correctly, we have seen a change and a modification of those laws. Rather than go through that process, I would urge the Western Australian Parliament to consider the fact that there will be this pressure to erode these laws—I do not think erosion is a good word, but to modify the laws to better serve the broader interests of the people. As time moves on in these 20 years, we are seeing a growing clamour for people to say, "Look, I want this option myself." In other words, we are seeing it finally coming to the point where people are saying, "This is not just some medical privilege for the very sick to be judged by a panel of doctors, but this is a fundamental human right." In the history of this issue with countries that have had 20 years or so experience with such laws, such as here [in the Netherlands], the question is now: is it a right or not for an elderly person to simply say, "If I want these drugs, I should be provided with them?" In other words, we are seeing a change from it being considered not just as a medical privilege for the seriously ill who qualify, but as a basic human right.*

...

*I want to see a debate held about a "tired of life" argument such as we are seeing here in the Netherlands. Should every person over a certain age be issued with those drugs? That is where the debate will go. I am predicting that. It will happen even in Western Australia and other Australian states, because that is where the debate around the world is heading.*<sup>795</sup>

- 3.268. Dr Syme also acknowledged a broadening of the scope of assisted suicide practice in countries with assisted suicide laws:

*Most of those countries **initially** regarded terminal illness as the critical point, but in fact the legislation was broader than that, and as time has gone on they have understood better the question of intolerable suffering. As a result, some other conditions, such as those I have mentioned, have come to be included in the criteria of acceptance. That*

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<sup>795</sup> Dr Nitschke, Exit International, JSCEOLC Transcript, 13 April 2018, Session 1 at 3 and p8 (emphasis added).

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*is not a slippery slope; that is simply a better understanding of the nature of the legislation.*<sup>796</sup>

- 3.269. Dr Syme's comments suggest that the original intent of the legislation in other jurisdictions was quite narrow and applied only to the rare cases of terminal and competent adult patients with severe suffering from a physical illness at end of life, but that over the passage of time, even where the wording of the legislation has not changed, the category of persons for whom the legislation was intended to apply has grown by interpretation to include children, persons with non-somatic illness and persons without capacity including Alzheimer's and dementia patients.
- 3.270. This expansion beyond the original intent of the legislation has been identified by opponents of assisted suicide legislation in their concern that it:

*is not just about later amendment of the original statute; even though that is also likely and the possibility of that is inherent in the enabling act. But it is also about interpretation and the reality that black-letter law is never going to be able to keep any legislation so tightly interpreted as always to reflect the original intentions.*<sup>797</sup>

- 3.271. Such a concern is not purely theoretical, but was evidenced in the administration of the ROTI Act, where a patient who was not suffering from a terminal illness was euthanised, to which Mr Perron, as Chief Minister and architect of the Northern Territory legislation responded that 'it was not necessarily in accordance with the legislation's intent, but no party involved regrets what they did in that circumstance.'<sup>798</sup> Kissane suggests that '[s]uch breaches of the Regulations were permitted by a legal system wanting to facilitate the legislation, thus removing the very safety features that had been designed to protect the vulnerable.'<sup>799</sup>
- 3.272. Dr Syme also, in effect, acknowledges that indeed the laws in the Netherlands have changed through judicial interpretation (as already identified earlier in this Chapter):

*The Netherlands have dealt with this issue through the courts and the courts have determined, and I agree, that a person with a severe, chronic psychiatric illness, which has been present for years and years and has been resistant to all treatment, may very well have severe intolerable suffering. You know, our suffering occurs in the mind. A very*

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796 Dr Syme, Medical Practitioner and Vice President of Dying with Dignity Victoria, JSCEOLC Transcript, 13 April 2018, Session 4 at 3 (emphasis added).

797 Paul Russell quoted in Debra Vermeer, 'Euthanasia – Quebec, Dutch, Belgian and Oregon laws a "mess",' *NewsWeekly*, 11 February 2017.

798 Mr Marshall Perron, Private Citizen, JSCEOLC Transcript, 13 April 2018, Session 2 at 9.

799 Kissane DW (2002) 'Deadly days in Darwin,' in *The Case Against Assisted Suicide*, Foley and Hendin (eds) at 192-209.

*famous Australian psychiatrist, whose name escapes my mind—he developed lithium for manic depression—said that depression is the most painful illness known to man, equal in severity to somebody suffering with cancer. It is undeniable that some people with chronic, untreatable psychiatric illness have the most severe suffering. Nevertheless, the Victorian Parliament decided that that was not to be part of the criteria, and I bow to their judgement, although, in my opinion, there is a sound argument for including such people, but that is a political judgement. Whether it is acceptable to your parliamentarians and the public is another matter.*<sup>800</sup>

- 3.273. In relation to the careful drafting of restrictive legislation to decriminalise assisted suicide in Western Australia, Dr Nitschke gave evidence to the Committee that:

*It is pragmatics. It is politics. I understand all that. But there are risks, too, because what you will get, and what the Victorians would get, I predict, is a law that very quickly comes under challenge from people saying this is inhumane and needs to be modified.*<sup>801</sup>

- 3.274. In order to avoid the ‘arduous process’ of future legislative amendment, Dr Nitschke made the following suggestion to the Committee:

*Yes, I think it might be wise just to omit the time line completely... In countries that have had legislation for a long time, that is generally where they have gone. They have tried to avoid the time line issue. They have tried to avoid statements such as “terminal” and used this idea of “chronic suffering” and, increasingly, as I have indicated, moved towards it simply being “patient request in the light of an informed decision”, with the patient deciding that their life is no longer worth living. That is going to take a while to get to, I suspect, in Australia, but I think that is ultimately where the laws will head. I suppose you can perhaps short-circuit or at least cut off some of the arduous process over the next few years by having some progressive legislation in place, get it through the Western Australian Parliament, to sort of bypass some of these inevitable pieces of conflict which will come up over the coming years.*<sup>802</sup>

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800 Dr Syme, Medical Practitioner and Vice President of Dying with Dignity Victoria, JSCEOLC Transcript, 13 April 2018, Session 4 at 9 (emphasis added).

801 Dr Nitschke, Exit International, JSCEOLC Transcript, 13 April 2018, Session 1 at 12 (emphasis added).

802 Ibid at 14 (emphasis added).

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- 3.275. Dr Nitschke's comments not only identify that the practice of assisted suicide in those countries where it has been legalised has modified over time, or moved toward a wider scope of operation, but also indicates that any so-called restrictive laws in Western Australia will also be challenged and change over time.
- 3.276. Opponents of assisted suicide have long called for caution and have identified that the category of persons able to access assisted suicide will expand:

*Past the door marked 'the terminally ill' are an endless number of other doors—the chronically ill, the demented, the crippled, the deformed, the chronically depressed, the terminally sad, the heartbroken, the hopeless, the unloved, the lonely, the simpletons, the economically unviable. Not to mention the passageway leading to the doors marked 'infants and children'.<sup>803</sup>*

- 3.277. Such statements are dismissed as scare mongering and a slippery slope argument unsubstantiated by fact.<sup>804</sup>
- 3.278. Yet the truth in the quote from Mr Michael Gawenda is evident in the very evidence presented by proponents of assisted suicide to the Committee, considered below, which illustrates that 'maintaining a line between killing which can or cannot be legally justified will be difficult'<sup>805</sup>. As the Dying with Dignity submission states:

*As in so many aspects of life, in the end this issue of boundaries on eligibility may come down to matters of fact and degree, and will call for the drawing of a line which will not completely satisfy many on either end of the debate spectrum, but which will represent a reasonable and sensible middle course.<sup>806</sup>*

- 3.279. The question then becomes where does this reasonable and sensible middle course lie?

### **Non terminal cases**

- 3.280. Given that it is the suffering of the patient that is central to the argument for legalising assisted suicide, it was suggested to the Committee that the requirement of terminal illness is actually counter-intuitive, and that the longer the person has to live with suffering, the more urgent their need for assisted suicide:

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803 Michael Gawenda, 'Change of heart on euthanasia,' *The Age*, 27 May 1996 at 15, quoted in Magnusson RS (2002) *Angels of death: exploring the euthanasia underground* at 231.

804 See Professors White and Willmott in White, McGee and Willmott 'As Victorian MPs debate assisted dying, it is vital they examine the evidence, not just the rhetoric,' (2017).

805 Sprung et al (2018) 'Physician-Assisted Suicide and Euthanasia: Emerging Issues from a Global Perspective' *Journal of Palliative Care* (sagepub.com/journalsPermissions.nav DOI: 10.1177/0825859718777325) at 2.

806 Dying with Dignity (WA), JSCEOLC Submission 565 at 19.



*If you have no quality of life, I could actually cope with knowing I have no quality of life but I have only six months to put up with it. If I knew I had 20 years to put up with it, I would want out. It is almost like it should be an inverse scale, from my appreciation.<sup>807</sup>*

- 3.281. In evidence to the Committee concerning the very real suffering of people with Huntington's disease, concern was raised that a conservative piece of legislation like that passed in Victoria would not allow access to assisted dying for Huntington's sufferers and that the law would require further amendment:

*There are so many other people who are going to be let down by these decisions. I am just asking you to take into account different scenarios. Do not make a law just because some other country is doing it. I think this is an opportunity for you guys to really assess what we need as a society and whether it is going to make a change to people, because you are going to be back here again talking about the same things because there are all these people who are not happy with the laws that you have made. I think society just has become complacent and people are not prepared to change and I think it is important that we do change and make a good change, and then we do not have to go back through this again.<sup>808</sup>*

- 3.282. Mr Ireland also gave evidence to the Committee that a requirement of terminal illness is too constraining:

*The very fact that I am here—I am asking you to broaden the scope of your legislative decisions, rather than Victoria. I would find the Victorian legislation very constraining in that it revolves around people who have a terminal illness. In my mother's case, she was not terminally ill. I believe that the focus on terminal illness and chronic illness needs to be broadened to the extent that it encompasses people like my mother, whose life was intolerable but not through terminal illness. My comment would be that I do not think the Victorian legislation goes far enough.<sup>809</sup>*

- 3.283. Magnusson notes that limiting assisted suicide to the terminally ill is not logically consistent with the two principles which underpin calls for assisted suicide, that of autonomy and the desire to end a person's suffering:

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807 Dr Beilby, Veterinarian, JSCEOLC Transcript, Session 11, 1 May 2018 at 4.

808 Mrs McBarron, Private Citizen, JSCEOLC Transcript, 30 April 2018, Session 8 at 3.

809 Mr Ireland, Private Citizen, JSCEOLC Transcript, 30 April 2018, Session 3 at 4.

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*More fundamentally, as Kamisar points out, ‘if either [respect for personal] autonomy or the merciful termination of an unendurable existence’ is the basis for the right to die, ‘why limit it to the terminally ill?’ Why not extend euthanasia as a choice for those whose chronic illnesses, injuries or disabilities (AIDS, spinal paralysis, advanced emphysema, amyotrophic lateral sclerosis, multiple sclerosis etc.) are the cause of chronic and intractable suffering? If self-determination and compassion are the controlling values, why limit assisted death to illness at all? Why not make it available to those who are constantly miserable?’<sup>810</sup>*

- 3.284. This is evident in this comment made by Mr William Spanbroek, following Mrs Katherine McBarron’s evidence above that restrictive legislation will prevent access for people suffering from Huntington’s disease, that:

*No, [the Victorian legislation] would not be enough, because the law should encompass every possibility in every illness. As Katherine said, everyone is different. For a person in a nursing home or a person dying of cancer or with what Michael died of or they are dying of emphysema, they are all different. It should not be six months. Far from it. We should do better than that and we have the opportunity to do better than that.<sup>811</sup>*

- 3.285. Similar sentiments were echoed by Ms Marcelle van Soest, who had witnessed the suffering of her husband who had died from Mesothelioma:

*I do not believe in the Victorian laws. I think they have not gone far enough. You have got to go through too much for a sick person to cope with. If you want to die, you should be allowed to die. It does not matter what other people think—family, friends, nobody. It is your life. If you have come to the end of the road and you feel that you do not want to be here anymore, you should not be, and that is how I feel.<sup>812</sup>*

- 3.286. To which Hon Dr Sally Talbot, Committee member, responded ‘That is a very clear statement and it has a lot of resonance in this room, I can tell you.’<sup>813</sup>

- 3.287. Calls for ‘death on demand’ are now being made in Canada and Dr Yves Roberts, a central advocate for the legalisation of assisted suicide in that country at the time at which the legislation was passed, has since expressed shock at what has happened in Quebec in

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810 Magnusson RS (2002) *Angels of death: exploring the euthanasia underground* at 275.

811 Mr Spanbroek, Private Citizen, JSCEOLC Transcript, 30 April 2018, Session 8 at 3-4.

812 Ms van Soest, Private Citizen, JSCEOLC Transcript, 1 May 2018, Session 4 at 8.

813 Hon Dr Sally Talbot, JSCEOLC Transcript, 1 May 2018, Session 4 at 8.

the two years since the passage of the Medical Assistance in Dying Act with calls for death on demand, and investigations into the extension of the laws to allow assisted suicide for mature minors, psychiatric illness and Alzheimer's and dementia.<sup>814</sup>

### The elderly

- 3.288. The extension of assisted suicide to include the elderly who are frail but otherwise physically well is made by Dr Syme:

*In my own workshops discussing end-of-life preparations, I never find a single person who is looking forward to entering a nursing home. Much of my counselling work involves talking to elderly folk living alone, whose dread is of being forced to enter a nursing home. They would prefer the choice of ending their life with dignity. As more people with experience of having placed their parents in nursing homes reach the prospect of a similar experience, the chorus of voices for another option will swell. Will their voices be heard?<sup>815</sup>*

- 3.289. When asked by the Committee what they thought of the Victorian legislation, euthanasia advocates for the elderly Mrs Trendall and Mrs Marshall replied:

*Mrs TRENDALL: I think it is a good start.*

*Mrs MARSHALL: As far as it goes—it has to go a bit further.<sup>816</sup>*

- 3.290. Dr Goodall, prior to his assisted suicide, stated that the passage of assisted suicide legislation, even a restrictive model, would be 'a step in the right direction' toward assisted suicide for the elderly:

*I certainly hope my story will increase the pressure for people to have a more liberal view on the subject of voluntary euthanasia ... I think there probably will be a step in the right direction.<sup>817</sup>*

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814 Yves Roberts MD, Secretary, College des medecines du Quebec, 'Towards death a la carte?' 10 May 2017 <<https://collectifmedecins.org/en/dr-roberts-regrets/>> referred to in evidence by Professor Somerville, Professor of Bioethics, University of Notre Dame Sydney, JSCEOLC Transcript, 1 May 2018, Session 8 at 3.

815 Syme R (2008) A good death: An argument for voluntary euthanasia at 198.

816 Mrs Trendall, Senior Citizen, and Mrs Marshall, Retired Public Servant and Senior Citizen, JSCEOLC Transcript, 7 March 2018, Session 1 at 6.

817 Claire Tyrell 'Euthanasia was Perth scientist David Goodall's dying wish,' *PerthNow*, 11 May 2018.

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### Children

- 3.291. Mr John McGrath, Committee member, expressed concern that euthanasia could be considered for children, saying ‘Most people would not agree with that principle, I am sure. Most people in society would not agree with that with children.’<sup>818</sup>
- 3.292. Yet, as has already been noted above, Dr Syme gave evidence to the Committee that ‘there is a very reasonable place for allowing children under 18 who have got the mental capacity to make these decisions, that that could be allowed,’ and that it would be discriminatory not to allow the euthanasia of minors.<sup>819</sup> Dr Syme writes in his submission ‘Does anyone think suffering from illness only starts at 18? It is well recognised by experienced paediatricians that children who suffer prolonged illness develop a maturity well beyond their years.’<sup>820</sup>
- 3.293. Stahle refers to this as a gradual disengagement of self-censure and of becoming accustomed to the abhorrent:

*Voltaire has said that those who can make you believe absurdities, can make you commit atrocities. The first absurdity may be to claim, against better knowledge, that it is possible to construct a safe system for the medical termination of people’s lives. Once that absurdity has been elevated to truth status, you and those you have seduced into agreeing, can actually end up supporting an activity that you initially felt was abhorrent—now with hardly any regrets at all. The abominable thing has thus been normalized or even glorified. Black has become white.*<sup>821</sup>

### Psychiatric illness

- 3.294. The Chief Psychiatrist of Western Australia, Dr Gibson, was adamant in his advice to the Committee that mental illness in the absence of any other qualifying illness should be an absolute exclusion category for assisted suicide and considered it ‘a slippery slope if we include any mental illness per se on that list [of illnesses for which assisted suicide should be available].’<sup>822</sup>

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818 Mr John McGrath, JSCEOLC Transcript, 1 May 2018, Session 6 at 4.

819 Dr Syme, Medical Practitioner and Vice President of Dying with Dignity Victoria, JSCEOLC Transcript, 13 April 2018, Session 4 at 3 and 4.

820 Dr Syme, Medical Practitioner and Vice President of Dying with Dignity Victoria, JSCEOLC Submission 316 at 5.

821 Stahle F (2017) ‘Moral disengagement – Mechanisms Propelling the Euthanasia/PAS Movement,’ *Journal of Ethics in Mental Health* 10 at 14.

822 Dr Gibson, Chief Psychiatrist of Western Australia, JSCEOLC Submission 655 at 4 and JSCEOLC Transcript, 14 December 2017, Session 5 at 5.

- 3.295. Despite admitting that ‘it is not possible to solve... everybody’s problems’ and his inability to help ‘Frank,’ a person suffering from mental illness, earlier in *A Good Death*, (considered above) Dr Syme continues

*The suffering that these people endure may be no less intolerable than those with severe physical illness—it may be worse, as John Cade asserts. Because we cannot see their disability does not mean it does not exist. They deserve our consideration. Making such assessments is a matter of high skill and the province of a panel of psychiatric experts, and should be done only after the apparent failure of prolonged, sustained and intensive treatment. There needs to be the utmost restraint, but the possibility should not be denied.*<sup>823</sup>

- 3.296. In the Netherlands, where assisted suicide was extended to people suffering from psychiatric illness through judicial interpretation, Dr Chabot, the psychiatrist involved in that landmark case, has recently expressed his total opposition to the current practice of euthanasia for those with psychiatric illness, and never anticipated at the time of his case the large number of cases for which euthanasia would be deemed acceptable.<sup>824</sup>

#### **Alzheimer’s disease and dementia**

- 3.297. Assisted suicide for Alzheimer’s and dementia patients is considered difficult as most legislative models (with the exception of the Netherlands and Belgium) require the person to have capacity at the time at which lethal medication is administered.
- 3.298. However, despite being firmly against assisted suicide for psychiatric illness in both his submission and in oral evidence given to the Committee, the Chief Psychiatrist of Western Australia acknowledged that excluding dementia as a mental illness from accessing voluntary assisted dying:

*is a really tough one, because someone may have had a lifelong view with regard to dementia, particularly in the context of having seen family members with dementia, and they may be very clear and it may be consistent over a long period of time that they would not wish to go through that process.*<sup>825</sup>

- 3.299. Alzheimer’s and dementia cases were considered by some proponents of assisted suicide as ‘a bridge too far’ at the present time:

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823 Syme R (2008) *A good death: An argument for voluntary euthanasia* at 223.

824 Prof Somerville, Professor of Bioethics, University of Notre Dame Sydney, JSCEOLC Transcript, 1 May 2018, Session 8 at 3; and see Dr Chabot’s interview in *Fatal Flaws: Legalizing Assisted Death* (2018) by Kevin Dunn.

825 Dr Gibson, Chief Psychiatrist of Western Australia, JSCEOLC Transcript, 14 December 2017, Session 4 at 3.

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Hon Dr SALLY TALBOT: *It is striking that on the list of underlying illnesses, we do not have dementia. Can you foresee any system of voluntary assisted dying that would include people with dementia?*

Mr HINDLE: *I do not think in the short term. I think that probably we will become a little more sophisticated with our advance health directives and that sort of thing. Maybe there will be a provision that a person can do an advance healthcare directive and say that if, in the event—because dementia is the greatest problem we are going to have in the future —*

Hon Dr SALLY TALBOT: *Do your members raise that as a reason for joining the organisation?*

Mr HINDLE: *Not necessarily. I think they would all like to have the opportunity if they became demented. But I do not think that they see that as a reality. I think they think that is probably a bridge too far. Who knows? It is a terrible disease. It is a condition so—*

Mr WALKER: *Sorry; can I add something again?*

Mr HINDLE: *Yes.*

Mr WALKER: *Many people raise it as a great concern and it seems to be one of those pressures that leads some people, I think, to take their lives sooner than otherwise they would have. They fear that they will lose capacity—we have not got a law yet, I know—they cannot communicate their wishes at the time when ideally they would want to, when they are in a certain kind of condition. I really have felt that some people have probably taken their lives sooner than they wanted to ideally because of the fear of dementia coming on.*<sup>826</sup>

3.300. Dr Syme also noted that:

*Dementia is the most difficult medical condition to deal with under this sort of approach. They cannot manage it, despite the fact that in the Netherlands they have been dealing with this effectively for over 35 years. We have not managed to really come to grips with the issue of dementia. In my opinion, it is the worst disease known to man, but it suffers from the extreme difficulty that by the time the person has truly intolerable suffering from their dementia, they are quite incapable of making any decision. I think it will take a lot of time for this issue to be*

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<sup>826</sup> Mr Hindle, President, Dying with Dignity (WA) and Mr Walker, Vice President, Dying with Dignity (WA), JSCEOLC Transcript, 13 April 2018, Session 5 at 10.

*resolved by humanity. My wife is currently suffering from dementia, so I am acutely aware of the problem, quite apart from my affirmative views. It is a tragic disease which we need to continue thinking about, but I do not think it is really effectively possible **at the present time** to include people with dementia in legislation.*<sup>827</sup>

- 3.301. Mr Denton also addressed the question of whether assisted suicide should be available for Alzheimer's sufferers in Australia:

*in Belgium and the Netherlands—the two places where people with dementia can legally be assisted to die; Canada is leaving its options open on it—there is division between doctors about whether or not this is something doctors should be doing. I strongly understand why they feel that way. I think it is a very, very difficult question. I do not think any doctor should be put in the position of assisting someone to die if they are not sure that that person is capable of making that request. Having said that, as I have gone around Australia speaking about this over the last three years, it is the number one question I am asked, and without fail it is the number one example I am given. We know that one in four Australians over the age of 80 suffer from dementia or some form of dementia or Alzheimer's. Even though I have seen the Netherlands model and I have admiration for it, I personally am not sure how it would be framed to help people with dementia in a way that does not put doctors in a very, very difficult situation. That being said, I do not think this is a question that is going to go away and whether it is addressed now, or in 20 years' time or 40 years' time, I think at some point, if this level of degenerative dementia in our society continues and possibly increases, then as a society we are going to want to work out how we deal with it.*<sup>828</sup>

- 3.302. These proponents note that while it is unlikely that Alzheimer's or dementia will be included in any present day legislation, the desirability of their inclusion to eligibility for assisted suicide in the future will remain.
- 3.303. Mr Walker of Dying with Dignity (WA) even suggested that, in light of recent advanced care directives legislation, that assisted suicide for Alzheimer's and dementia patients may in fact be possible in Victoria:

*We note that in Canada, that issue of capacity, including, I think, those who have lost capacity even before qualifying—the classic Alzheimer's*

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827 Dr Syme, Medical Practitioner and Vice President of Dying with Dignity Victoria, JSCEOLC Transcript, 13 April 2018, Session 4 at 7.

828 Mr Denton, Go Gentle Australia, JSCEOLC Transcript, 13 April 2018, Session 6 at 7.

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*cases—has been deferred for further consideration by the Canadian Parliament in December of this year. It is not a lost issue, but it is of importance. Victoria has implemented, as the committee would be well aware, quite new and detailed advance care directives under separate legislation, which on one view would appear to allow—there has been a recent article to this effect—perhaps the Alzheimer’s patient to provide an advance healthcare directive concerning assistance in dying at a particular point, and arguably that is now going to be the scheme operating in Victoria. We would suggest that that could be closely considered here.*<sup>829</sup>

- 3.304. In Canada, as has already been highlighted in this Report in the section entitled ‘*The North American Experience—Canada*,’ the Health Department is currently considering whether to extend assisted suicide to patients suffering from Alzheimer’s disease. Furthermore, a 2017 survey of Quebec caregivers found that 91 per cent of respondents were in favour of extending medical aid in dying to those suffering from Alzheimer’s and dementia, and 72 per cent said they were for assisted dying of Alzheimer’s patients who did not sign a written directive before their illness.<sup>830</sup>
- 3.305. In relation to Motor Neurone Disease, evidence was given by the Motor Neurone Disease Association Western Australia that they would be supportive of legislation to allow a person with the disease to put into an advance health directive that they have successfully negotiated a voluntary assisted dying contract to be activated under certain circumstances, *including the advent of a more severe dementia.*<sup>831</sup> There was no concern expressed by the Association that the patient would no longer have capacity at the time at which the lethal medication is administered by a medical practitioner (with patient administration impossible at that point).
- 3.306. The suggestion that advance health directives can safely provide for the patient’s long held wishes to be carried out after capacity is lost should be considered in light of the Netherlands’ experience of the euthanasia of Alzheimer’s and dementia patients. Dutch authorities are currently investigating the death of an Alzheimer’s patient who had previously written in a living will that she wanted to be euthanised ‘whenever I think the time is right.’ Later, the patient said several times in response to being asked if she wanted to die: ‘But not just now, it’s not so bad yet!’ This patient was drugged by her physician to deliberately reduce her consciousness so as to avoid her resisting being given drugs. Despite this, the patient struggled against the administration of an

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829 Mr Walker, Vice President, Dying with Dignity (WA), JSCEOLC Transcript, 13 April 2018, Session 5 at 4-5.

830 Aaron Derfel, ‘Most caregivers favour assisted dying for Alzheimer’s patients: survey,’ *Montreal Gazette*, 21 September 2017.

831 Motor Neurone Disease Association (WA), JSCEOLC Response to Questions on Notice, undated at 7.



intravenous lethal injection and was physically restrained by family members to allow the physician to complete the euthanasia. The doctor claimed that she was fulfilling a written request the patient had made for euthanasia years earlier and that since the patient was not competent, nothing the woman said during her euthanasia procedure was relevant.<sup>832</sup>

- 3.307. Dr Sinclair and Associate Professor Blake also recommended to the Committee that the Victorian model is too narrow, in that it excludes access to assisted dying via advance directives, and that the Committee should consider the rationale behind the ‘contemporaneous request’ (versus the ‘anticipatory request’) model given the strong support for end-of-life planning in the legislation in many Australian jurisdictions.<sup>833</sup>
- 3.308. Dr Khorshid gave evidence that allowing assisted suicide for a patient after loss of capacity through an advance health directive is a very dangerous position to hold:

*Advance healthcare directives are directives. They are legally binding documents set at a particular point in time. We believe that decisions around end-of-life care are much more fluid; that patients change their minds as they go through a disease process. At some points in a disease process they can be wanting to end their life and then they can come out of that a week later as symptoms resolve et cetera. It is a very fluid process. Having a direction to end someone’s life in a legally binding document is very, very dangerous in our view. The patient at the time of the act would potentially not be competent and that is getting awfully close—in our view it is crossing the line into active euthanasia; into doctors choosing to end someone’s life. We would be very strongly opposed to that.*<sup>834</sup>

- 3.309. On whether assisted suicide may be presented as the solution to the ‘dementia problem,’ Mr Harkness gave evidence to the Committee that:

*I am mindful of Australia having been at the forefront of research into the prevention and treatment of Alzheimer’s disease. It is alarming that advocates of euthanasia sometimes argue that doctor assisted suicide would enable people with dementia a release from their burden. As a former lecturer in Certificate 111 Aged Care, and in which I delivered a*

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832 Regionale Toetsingscommissies Euthanasie, Jaarverslag 2016, p. 54-58 <<https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2016/april/12/jaarverslag-2016/RTEjv2016.pdf>>, Regional Euthanasia Review Committees *Annual Report 2016* <[https://english.euthanasiecommissie.nl/binaries/euthanasiecommissie-en/documents/publications/annual-reports/2002/annual-reports/annual-reports/RTE\\_annual\\_report\\_2016.pdf](https://english.euthanasiecommissie.nl/binaries/euthanasiecommissie-en/documents/publications/annual-reports/2002/annual-reports/annual-reports/RTE_annual_report_2016.pdf)>

833 Assoc Prof Blake and Dr Sinclair, University of Western Australia, JSCEOLC Submission 584 at 9.

834 Dr Khorshid, President, AMA(WA), JSCEOLC Transcript, 28 February 2018, Session 2 at 19.

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*module on Dementia, I spoke about many employment areas that contained a focus on maintaining, and indeed promoting, the health and wellbeing of this group of predominantly elderly. These include, but were not limited to, nursing, personal care, physiotherapy, and occupational therapy. Will a relaxation of euthanasia legislation lead to a disincentive for graduating students in these fields to work in the area of the elderly, even at a time when the population of elderly in Australia is increasing exponentially?*<sup>835</sup>

- 3.310. Alzheimer's disease and dementia are on the rise, and how we can better care for sufferers of these diseases at the end of their lives is a critical matter to address. However, the words of Canadian physician Dr Rene Leiva should be heeded. He asks, 'whose suffering does [assisted suicide] really eliminate? ...It certainly eliminates the sufferer, whose pain we are not able to bear.'<sup>836</sup> Mr Denton suggests that the problem of whether to allow assisted suicide for Alzheimer's patients will not go away and that it will be addressed at some point. The 'Alzheimer's problem' is yet another example of how difficult it is to maintain a line between killing which can be justified and that which cannot.
- 3.311. In light of the evidence of logical incremental extension in jurisdictions that have legalised assisted suicide and in evidence given to the Committee by proponents of assisted suicide for Western Australia above, barrister and former Labor MP Tim Hammond's comment is apt:

*Perhaps the most troubling thing about the prospect of lawful euthanasia is that we don't know where it will end up... I have a terrible feeling that once we start up this ride, we won't be able to get off it.*<sup>837</sup>

- 3.312. Similarly, former Labor Prime Minister Paul Keating has said:

*once termination of life is authorised the threshold is crossed. From that point it is much easier to liberalise the conditions governing the law. And liberalised they will be. Few people familiar with our politics would doubt that pressure would mount for further liberalisation based on the demand that people are being discriminated against if denied. The experience of overseas jurisdictions suggests the pressures for further liberalisation are irresistible.*<sup>838</sup>

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835 Christopher Harkness, Private Citizen, JSCEOLC Submission 266 at 3.

836 Leiva RA (2010) 'Death, suffering and euthanasia,' *Canadian Family Physician* 56(6) at 528-530.

837 Tim Hammond 'Euthanasia and why I'm against it,' *PerthNow*, 17 December 2017.

838 Paul Keating, 'Voluntary euthanasia is a threshold moment for Australia, and one we should not cross,' *Sydney Morning Herald*, 19 October 2017.

3.313. The threshold to allow assistance to suicide should not be crossed in Western Australia.

**Finding 122**

A 2013 review by the High Court of Ireland of the available evidence from jurisdictions with assisted suicide produced the conclusions that the examples of abuse are deeply disturbing, that certain groups are vulnerable to abuse, and that the number of suicides remain strikingly high.

**Finding 123**

Unlike other jurisdictions, there is yet to be any lived experience with the Victorian model of assisted suicide.

**Finding 124**

The Victorian model of assisted suicide has been heavily criticised by proponents of assisted suicide, with calls to extend the scope already made before the law has even come into force.

**Finding 125**

It is a political inevitability that once lawmakers introduce a right for one group of people that others will soon demand the extension of that right to them on the ground of equality.

**Finding 126**

Any restriction on eligibility within an assisted suicide regime is both arbitrary and discriminatory.

**Finding 127**

It is at best premature to base any assisted suicide regime on the untested Victorian model.

**Recommendation 20**

The Government and the Parliament of Western Australia should rule out introducing an assisted suicide regime based on the untested Victorian model.

A handwritten signature in blue ink, appearing to be 'Nick Goiran', written on a light pink background.

**Hon Nick Goiran MLC**