



**LEGISLATIVE ASSEMBLY**  
FOR THE AUSTRALIAN CAPITAL TERRITORY

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**SELECT COMMITTEE ON END OF LIFE CHOICES IN THE ACT**

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Mrs Elizabeth Kikkert MLA, Ms Caroline Le Couteur MLA.

## Submission Cover Sheet

### End of Life Choices in the ACT

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**SUBMISSION TO SELECT COMMITTEE ON END OF LIFE CHOICES IN THE ACT**

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## **WHO WE ARE**

Dying with Dignity NSW (DWD NSW) is an active law reform organisation pursuing a change in the law that will enhance self-determination and dignity at the end of life. Our aim is legislation that entitles a mentally competent adult experiencing unrelievable suffering from a terminal or incurable illness to receive medical assistance to end their life peacefully, if that is what he or she wants. As well as our role in advocacy and lobbying to bring about a change in the law, we promote the use of Advance Care Directives to assist with patient control at the end of life (EOL) and we provide our members with information about changes in the legal climate for EOL, both in Australia and overseas. We are a not-for-profit organisation limited by guarantee and we rely on membership, donations and bequests in order to continue our work.

DWD NSW supports the initiation of the ACT Inquiry into End of Life Choices and welcomes the fact that it will foster an informed and much-needed debate about EOL decision-making in Australia, a process which will benefit both the ACT and the other states and territories. The question of end of life choices, including the possibility of a request for voluntary assisted dying (VAD), is a very emotional issue about which there is much fear-mongering and misinformation. We urge the Select Committee to conduct a rigorous and open-minded examination of the evidence from jurisdictions in which regimes of physician-assisted dying exist to determine whether in fact there is any evidence of abuse. DWD NSW believes that research conducted by both the regulatory bodies and independent academic researchers indicates that, with appropriate safeguards and monitoring, such regimes operate safely.

In what follows we address ourselves to Terms of Reference (2), (3) and (4).

In Part I we argue why we believe a Voluntary Assisted Dying (VAD) law is needed and in Part II we examine and critique the arguments generally made against VAD.

## **PART I: WHY A BILL TO ALLOW VOLUNTARY-ASSISTED DYING (VAD) IS NEEDED**

### *Patients' Rights and Autonomy*

DWD NSW believes that just as patients currently have control over the kind and extent of medical treatments they receive, they should also have control over the time and circumstances of their dying as long as appropriate safeguards are in place. This has been expressed as follows: “a competent terminally ill patient seeking a quick painless death does not represent any harm to others in society and in the absence of such a threat the state does not have the right to subjugate the individual’s autonomy”. (1)

### *Compassion*

In a situation where a person is undergoing unbearable pain and suffering, either physical or mental, and where there are no reasonable measures which might relieve that suffering, it is a compassionate society which provides a safe environment in which such a person can ask for assistance to die. An appropriate legal framework would also provide protection for doctors who wish to compassionately assist a patient, in line with their duty of care, but who at present are not protected if they do so.

### *Loss of dignity and loss of quality of life*

As demonstrated by the experience in Oregon (2), where assisted dying is legal, the most important reason given by patients for requesting assisted dying is the loss of dignity and diminution in quality of life suffered by patients in the last stages of a terminal illness or degenerative disease (3). Often in such circumstances all normal autonomous action (for example, communication, control over movement, control over urination and defecation, ability to clean and dress oneself, ability to swallow) is impossible and all quality of life is lost, that is, all the activities that used to give purpose and meaning to the person are no longer available.

*Existing End of Life (EOL) management*

A number of EOL practices are currently standard, including opioid use, withholding or withdrawing of treatment (such as CPR, antibiotics and artificial ventilation), withdrawal of artificial nutrition and hydration (ANH) and terminal sedation. In these cases patients die over a relatively longer period, often of starvation and thirst, and often in a coma. We argue that such treatments are not dignified or effective in that they extend life but not in a way that is profitable to the patient. We argue that in appropriate circumstances, and when requested by the patient, that assisted dying should be another option in the suite of EOL practices and be a natural part of good patient care, and within the offerings of normal palliative care.

An additional point here is that at the moment, in the absence of a clear framework for EOL decision-making, there are some legal grey areas even in the existing range of options available and having a clear assisted dying regime would also provide a safer framework in which to offer treatments such as withdrawal of ANH and terminal sedation.

*Euthanasia and Assisted Dying now occurring “under the table”*

There is considerable evidence from both Australia and overseas to show that there is a “euthanasia underground”. This evidence is summarised in the *Australia 21 Report*, as follows:

“A study by Kuhse et. al. concluded that in 1995-6, 1.8% of all deaths in Australia occurred due to VE and 0.1% were due to voluntary assisted dying (VAD). ...[T]hese statistics are broadly comparable with the position in permissive jurisdictions.” [4] A qualitative study by Magnusson documented sustained unlawful conduct relating to voluntary euthanasia (VE) and assisted suicide (AS) [5]. There is also a body of anecdotal evidence. In 1995 seven Melbourne doctors (one of whom was Dr. Rodney Syme) published an open letter to the Victorian premier admitting to having performed euthanasia.”

In addition, the absence of a regime for assisted dying has meant that desperate individuals have been taking extreme steps to end their lives when their suffering has become intolerable. This includes suicide by various gruesome means such as hanging, poisoning, suffocation etc. Australian Bureau of Statistics figures show that “the oldest group (85 years and over) [had] the highest suicide rate (28.2 per 100,000) in [2009](#).” (6)

During the Victorian Parliament’s inquiry into end of life choices, the Victorian coroner presented stark evidence about the number of elderly people committing suicide because of severe end of life pain and suffering for which the medical establishment could provide no relief. He reported that such deaths were occurring at the rate of about one a week. The methods used included hanging, severing wrists, poison and firearms. All these people died alone and in great agony because of the absence of a compassionate alternative. (7)

*In some cases, palliative care is insufficient*

Palliative Care Australia acknowledges that even with access to the very best palliative care services, in some cases the management of a patient’s suffering is intractable.

In a 2006 policy statement Palliative Care Australia Council wrote,

“While pain and other symptoms can be helped, complete relief of suffering is not always possible, even with optimal palliative care.”

*The Termination of Life on Request and Assisted Suicide (Review Procedures) Act in Practice* report published by the Netherlands Ministry of Foreign Affairs in 2010 says,

“Unfortunately, even where patients are receiving palliative care of the highest quality, they may still regard their suffering as unbearable and plead with their doctors to terminate their lives. In such cases, euthanasia could represent a dignified conclusion to good palliative care.”

Australian data on the effectiveness of palliative care supports the overseas findings. Based on data collected by approximately 100 palliative care facilities across Australia every year, we know that a small yet significant percentage of dying patients cannot have their symptoms controlled, even with the best efforts of palliative care. The most recent report from the “Palliative Outcomes Collaboration Report 2016” shows that the percentage of patients experiencing severe pain can be as high as 10.3% in the unstable phase of their illness and for patients in the terminal phase of their illness 3.6% had severe pain, 3% had severe psychological distress and 6.5% had other severe physical symptoms such as breathing problems , choking and nausea[8].

Many of our members and members of the community regularly report their personal stories to DWD NSW. Often, these include harrowing accounts of a loved one with intolerable suffering for whom all treatment, including palliative care, was futile. In these rare cases it is of paramount importance that Australia has in place a coherent and transparent regulatory framework that brings matters into the open and protects both medical practitioners and suffering individuals.

*Assisted dying and palliative care are not alternatives – they go and should go together.*

Critics of VAD law reform often pose palliative care as if it were inevitably a better alternative and as if it is an either/or situation, that is, either VAD or palliative care. But many of the best-informed advocates of end of life choice are palliative care specialists and see VAD as part of good palliative care and as part of the spectrum of options available.

This view was continually emphasised by the Falconer Report in the UK which saw any assisted dying regime to be part of a holistic national plan to improve health and social care services and support universal access to high quality end of life care (9). It also reported research by the European Commission showing that palliative care is highly developed in those countries with assisted dying regimes and indeed, the standard of palliative care in Belgium and the Netherlands has improved since their schemes were introduced.

Dr Timothy Quill, one of the world's leading experts on palliative care and an advocate for strictly regulated assisted dying has the following to say:

“Let me begin by reinforcing that excellent palliative care should be the standard of care for all dying patients, and no patient should be medically assisted with a hastened death because she is not receiving the standard of care. Palliative care, if applied with skill and expertise, can address most, but not all, end-of-life suffering. ... But a small percentage of dying patients will still experience suffering that can become intolerable and unacceptable, and a sub-set of those will want assistance helping death come earlier rather than later”. (10)

#### *Australians want assisted dying law reform*

Opinion polls in Australia consistently show strong support for a regime of voluntary assisted dying. Polls taken by a variety of polling organisations over the last ten years have registered rates of between 70% and 85% for change. (For more information go to the DWDnsw web-site <http://dwdnsw.org.au/faqs/>.)

## **PART II: OPPOSITION TO THE IDEA OF VOLUNTARY ASSISTED DYING (VAD)**

### *Religious opposition*

Much opposition to VAD stems from religious conviction. We respect people's right to a conscientious objection to VAD and would not be in favour of compelling doctors with such a position to carry out VAD. We also respect the right of people with religiously based convictions against VAD to not participate in such practices themselves. However, we firmly believe that people with such religious objections should not impose their convictions on those who do not share their beliefs.

We note that there is nothing inherent in having religious faith that prevents a person being in favour of VAD. The organisation, Christians Supporting Choice for Voluntary Euthanasia, is of the view that a Christian view of compassion would lead to the position that in some circumstances, VAD is merciful and therefore virtuous. A number of eminent figures in the Christian faith have been

outspoken in their advocacy for VAD, notably Archbishop Desmond Tutu of South Africa and the ex-Archbishop of Canterbury, Dr George Carey.

### *The “Slippery Slope”*

Opponents of VAD adduce the experience of the Netherlands and Belgium to argue that once you allow VAD for terminally ill people, it is soon extended to other categories, such as people who are “tired of life”, those with debilitating but non-terminal illnesses, the mentally ill, the handicapped and children. But this is a specious argument. There is no automatic slippery slope. Any change to a regime of VAD could not be introduced at the whim of the doctors. A regime with strict safeguards, such as those that have been envisaged in Bills introduced in both the Tasmanian and NSW parliaments in recent years and the one passed in Victoria, would not permit any automatic extension to new categories of cases. Any changes would have to be debated in the community and introduced by legislation after rigorous examination by the relevant parliament.

### *Risk of abuse*

Opponents of VAD often say, “I could not support a regime of VAD if there was even the slightest risk of it being abused.” This is to demand a level of risk avoidance that we do not demand in any other area of life. Consider our attitudes to driving. We know that driving on our roads carries what might be considered quite a high risk of injury and death. We do not say “If there is even the tiniest risk of injury or death from driving, we should ban driving cars.” What we do instead is operate a system of regulation and sanction that seeks to limit the risk to an acceptable level. It would be foolish of proponents of VAD to argue that it is possible to devise a framework for the practice that would reduce the level of risk to zero. Rather, what we would do is have a set of safeguards that minimized the risk. Most regimes that have hitherto envisaged in Australia, including the Victorian, Tasmanian and NSW cases mentioned before, have contained what might be consider almost overly strict requirements for a person to be able to lawfully ask for help to die. These include:

examination by two independent medical practitioners,

a psychiatric examination, attesting that the person has decision-making capacity,  
absence of coercion,  
a requirement that all treatments, including palliation have been tried,  
the prohibition of anyone who stands to gain from the death from participating at any stage of the process,  
oversight by a regulatory body,

Such a regime would have a negligible level of risk attached to it.

### *Other jurisdictions*

As outlined above the two jurisdictions that are most often mentioned by opponents of VAD as “horror stories” are the Netherlands and Belgium. But the regimes for VAD (or voluntary euthanasia) that have been established in those two countries are very different in nature from anything ever envisaged for Australia. However, conveniently, another case, much closer to what would be envisaged in Australia, namely Oregon, is not mentioned. This is because the case of Oregon does not support any attempt at beating up fear about VAD.

### **CONCLUSION**

DWDnsw places emphasis on the principle of autonomy when considering end of life care. It should be a matter for the patient to decide what constitutes intolerable suffering and which treatment options best suit them. As a patron of the advocacy organisation Dying In Dignity UK, Sir Patrick Stewart said,

“We have no control over how we arrive in the world. But at the end of life we should have legal control over how we leave it.”

The Netherlands Report mentioned above reads,

“Experience shows that many patients find sufficient peace of mind in the knowledge that the doctor is prepared to perform euthanasia and that they ultimately die a natural death.”<sup>i</sup>

According to the Oregon Health Authority's [Annual Reports](#) on *The Oregon Death With Dignity Act*, on average one third of patients prescribed life-ending medication in accordance with the act do not take the medication and subsequently died of other causes. However, it is reported that just having the medication, which they know can be used if their situation becomes intolerable, eases the patient's mind and gives them extra strength to carry their burden.

And as stated earlier, a competent terminally ill patient seeking a quick painless death does not represent any harm to others in society and in the absence of such a threat the state does not have the right to subjugate the individual's autonomy.

We attach two documents authored by Dying With Dignity NSW that were used during the recent campaign in NSW. Their titles are: "Assisted Dying: Setting the Record Straight" and "Assisted Dying: Some Frequently Asked Questions". They contain very recent data and proved very useful tools to enable busy politicians to access the necessary information in a brief form leading up to the parliamentary debate.

We also attach a very distressing story related to DWD NSW by a member of the public who rang our organisation because he worked out that he would get a sympathetic hearing. This experience has convinced the person that the option of a physician-assisted death must be available. DWD NSW receives similar stories on a weekly basis. There is a lot of desperation in the community about the limited set of options at the end of life.

**Footnotes**

1. Giddings Lara and McKim Nick, "Voluntary Assisted Dying: Short Companion Paper to the Consultation Paper: A Proposal for Tasmania", February 2013, p. 6.
2. Linda Ganzini (2016), "Legalised Physician-Assisted Death in Oregon", QUT Law Review, pp. 76-83.
3. Lara Giddings and Nick McKim, Voluntary Assisted Dying, A Proposal for Tasmania, February 2013, p. 90.
4. Ben White and Lindy Willmott, *How Should Australia regulate voluntary euthanasia and assisted suicide?*, Australia 21 Report, Queensland University of Technology, 2012, p. 20.
5. Roger Magnusson, *Angels of Death: Exploring the Euthanasia Underground*, Melbourne University Press, 1998.
6. Australian Bureau of Statistics, 4125.0 – Gender Indicators, Australia, Jan 2012
7. Parliament of Victoria (2016), *Inquiry into End of life Choices, Final Report*, p. 193 ff.
8. Connolly A, Bird S, Allingham S, Bishop G, Langdon T, Clapham S, Quinsey K and Foskett L (2016) *Patient Outcomes in Palliative Care for New South Wales and Australian Capital Territory, State compendium report, January to June 2016*. Palliative Care Outcomes Collaboration, Australian Health Services Research Institute, University of Wollongong.
9. *Commission on Assisted Dying Report* (the Falconer Report), Parliament of the United Kingdom, 2011, p. 20.
10. Timothy E Quill, 'Physicians Should "Assist in Suicide" When It Is Appropriate', *Journal of Law, Medicine and Ethics*, Spring 2012, p, 57-8.

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**ASSISTED DYING:**  
**SETTING**  
**THE**  
**RECORD**  
**STRAIGHT.**

Dying with Dignity   
New South Wales



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# THE FACTS.

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**73%** OF AUSTRALIANS

**SUPPORT THE CHOICE OF  
ASSISTED DYING FOR  
TERMINALLY ILL PEOPLE**

**AND ONLY 15% OPPOSE** <sup>1.</sup>

An assisted dying law is needed because the current law is failing many Australians.

Based on findings from the Victorian Parliamentary Inquiry Into End Of Life Choices, <sup>2.</sup> the most comprehensive inquiry of its kind ever held in Australia, we know every year:

- Desperate, terminally ill Australians are ending their own lives, often in horrific circumstances.
- Families are being traumatised after witnessing the 'bad deaths' of loved ones.
- There are repeated examples of inadequate pain relief being delivered to dying patients by doctors for fear of breaking the law.
- Despite its many benefits, palliative care is unable to relieve all suffering.
- People are being put on trial for helping those they love find a merciful end.
- Doctors are being forced to break the law in order to help their patients die, but are doing so without support, regulation, or accountability.
- With few legal options, some seriously ill Australians are refusing food and water to expedite death and finally relieve their suffering.

**WE CANNOT ALLOW THE SUFFERING TO CONTINUE.**

**WE NEED A VOLUNTARY ASSISTED DYING LAW  
WITH STRICT SAFEGUARDS.**

# DISPELLING THE MYTHS.

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Despite the overwhelming support in the community and despite the evidence that maintaining the status quo is unacceptable, the vocal minority who oppose assisted dying laws have to date been successful in blocking this legislation.

Opponents go to great lengths to plant seeds of fear, uncertainty and doubt in the minds of the general public, but more importantly, in the minds of politicians. They use misinformation and 'cherry picked' statistics to divert the debate away from sensible and evidence-based arguments into the realm of distortion and scaremongering.

Opponents often refer to 'euthanasia', which is misleading in the Australian context. Euthanasia refers to the administration of life-ending medication by a doctor. The proposed Voluntary Assisted Dying laws in NSW and Victoria would legalise voluntary assisted dying – where patients who meet strict eligibility criteria would be prescribed medication to end their own lives. It would only be in rare circumstances, where a patient is unable to self-administer, that a doctor would be able to administer the medication.

The NSW Voluntary Assisted Dying Bill 2017 is modelled on the law in Oregon, USA, with even stricter safeguards. The Death With Dignity Act has been operating safely for twenty years and has since been adopted by five other US states and Washington DC. The NSW Bill would only apply to mentally competent, terminally ill adults who have a prognosis of less than twelve months to live. The NSW Bill is different to the laws in Belgium or the Netherlands, which were much wider in scope from the outset and based on a broad criterion of suffering—not necessarily linked to a terminal illness; comparison to these laws is misleading.

As more and more jurisdictions around the world introduce assisted dying laws, the opponents' arguments are becoming weaker. However, they continue to spread misinformation and create new arguments because, as former New Hampshire legislator, Nancy Elliott, explained at an anti-euthanasia conference in Adelaide in 2015:

*"When you have lots of arguments, if one argument gets blown out of the water, you still have more, and each argument will reach somebody else."*

*"You only have to convince legislators that they don't want this bill. You don't have to win their hearts and minds; all you have to do is get them to say, 'Not this bill', and then you have got your win."<sup>3</sup>*

## AUSTRALIANS DESERVE A DIGNIFIED, RESPECTFUL AND EVIDENCE-BASED DEBATE ABOUT ASSISTED DYING.

We encourage all members of the NSW Parliament, as well as journalists and the general public, to examine the evidence and not be distracted by the 'myths' being promoted by opponents. Decisions should be made on facts, not fear.

Terminally ill people deserve the compassion and protection of a robust law, with strict safeguards. They also deserve an informed, evidence-based debate when lawmakers are determining what end-of-life choices should be available to them. In order for this to be achieved, some common myths must be dispelled.

If you would like any further information or references, contact Dying With Dignity NSW:

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Website: [www.dwdnsw.org.au](http://www.dwdnsw.org.au)

# VULNERABLE PEOPLE.

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## MYTH

### POTENTIALLY VULNERABLE PEOPLE, SUCH AS THE ELDERLY OR DISABLED, WILL BE AT RISK UNDER A VOLUNTARY ASSISTED DYING LAW.

Where voluntary assisted dying is legal there is no evidence that potentially vulnerable groups such as the over-85s, disabled people, people of lower socio-economic status and those with mental health problems are adversely affected. <sup>4</sup> Research has found in no jurisdiction was there evidence that vulnerable patients have been receiving euthanasia or voluntary assisted dying at rates higher than those in the general population. <sup>5</sup>

The law proposed in NSW requires that a person be suffering from a terminal illness which, in reasonable medical judgement, will result in the death of the patient within 12 months. They also have to be experiencing severe pain, suffering or physical incapacity to an extent deemed unacceptable to the patient, and eligibility has to be confirmed by two medical practitioners and a psychiatrist, or clinical psychologist to confirm mental competence. The NSW Bill also contains additional safeguards to the Oregon law, including a framework for judicial review to the Supreme Court. There is far more involved in the decision than a patient merely requesting it. <sup>6</sup>

## MYTH

### IN OREGON AND WASHINGTON, WHERE ASSISTED DYING IS LEGAL, 'FEELING A BURDEN' IS REGULARLY CITED AS A REASON FOR A REQUEST.

Patients who request assisted dying in Oregon and Washington give several reasons for their choice - burden falls low on the list. The key reasons for requesting assistance to die in both States are loss of autonomy (c.90%), being less able to engage in enjoyable activities (c.88%) and loss of dignity (c.79%). Burden is less frequently cited (40% in Oregon and 59% in Washington), with research showing that this can reflect patients' own feelings, rather than how caregivers view them. Caregivers find positive meaning in caring for terminally ill family members who have requested assisted dying. <sup>7</sup>

Under the proposed Bill, two doctors and a psychiatrist or clinical psychologist would be required to independently assess the person making a request, including exploring the reasoning and motivations for a request to ensure there is no coercion. The person can also change their mind at any point.

## MYTH

### AN ASSISTED DYING LAW WOULD BE THE START OF A SLIPPERY SLOPE.

In Oregon, where an assisted dying law has operated safely since 1997, there have been no cases of abuse of the law and no widening of its initial, limited scope. Assisted deaths in Oregon account for just 0.4% of total deaths. <sup>8</sup>

Those opposed to assisted dying often cite the wider eligibility criteria of the laws operating in Belgium and the Netherlands, but these have always been much wider in scope than the Voluntary Assisted Dying Bill and do not therefore represent a slippery slope. The law you enact is the law you get.

Research of jurisdictions that allow assisted dying shows that the concerns about abuse have not eventuated. The eligibility criteria and safeguards are restricting access to only those who qualify, and protecting vulnerable people. <sup>2</sup>

**MYTH****MENTAL CAPACITY CANNOT BE RELIABLY ASSESSED.**

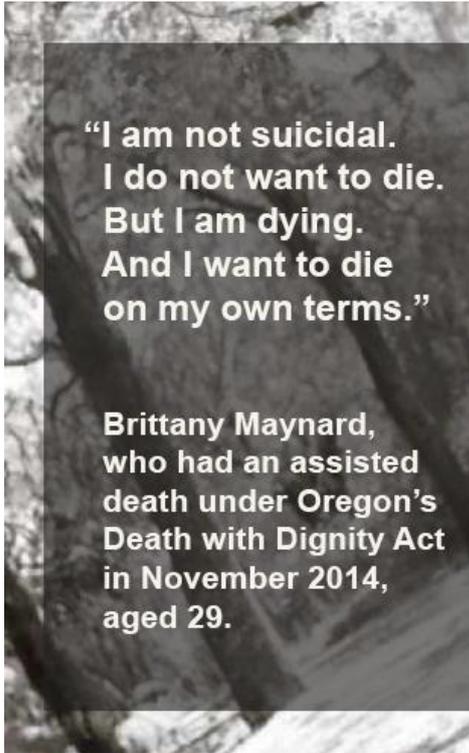
Doctors routinely assess mental capacity as part of their day-to-day duties. Determining mental capacity already plays a key role in end-of-life decision making, such as the right to refuse treatment. However, the Voluntary Assisted Dying Bill has the added safeguard of a mandatory assessment by either a psychiatrist or psychologist to confirm the patient is of sound mind, has decision-making capacity, and is making their decision freely and voluntarily and after due consideration.

**MYTH****IN OREGON, PEOPLE WITH DEPRESSION HAVE HAD AN ASSISTED DEATH.**

A level of sadness is normal in terminally ill patients.<sup>9</sup> Research from Oregon found that whilst some requesting patients presented some of the symptoms associated with depression (weight loss, fatigue, loss of appetite etc.), these are common symptoms of terminal illness. There was no evidence to suggest these people were suffering from clinical depression.<sup>10</sup> The mandatory assessment by a psychiatrist or psychologist in the NSW Bill provides an additional safeguard in regard to the question of mental illness.

**MYTH****ASSISTED DYING IS SUICIDE, LEGISLATING FOR IT SENDS A DANGEROUS MESSAGE TO SOCIETY AS A WHOLE.**

Dying people who want to control the manner and timing of their death are not suicidal. Oregon's Death With Dignity Act itself states that a death under its provision is not a suicide — there being major differences between a rational and fully informed choice in the face of intolerable and unrelievable end-of-life symptoms, and irrational choices about transient problems.<sup>11</sup>



**“I am not suicidal.  
I do not want to die.  
But I am dying.  
And I want to die  
on my own terms.”**

**Brittany Maynard,  
who had an assisted  
death under Oregon's  
Death with Dignity Act  
in November 2014,  
aged 29.**

# PUBLIC SUPPORT.

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## MYTH

### THE GENERAL PUBLIC IS DIVIDED ON THE ISSUE OF ASSISTED DYING.

The general public overwhelmingly supports a change in the law on assisted dying. Opinion polls conducted in Australia over many years have consistently shown support ranging from 70% to 85%. In 2015, an Ipsos/MORI poll showed 73% of Australians agreed that "it should be legal for a doctor to assist a patient aged 18 or over to end their life, if that is the patient's wish, provided that the patient is terminally ill, of sound mind and expresses a clear desire to end their life." <sup>12.</sup>

## MYTH

### RELIGIOUS PEOPLE ARE OPPOSED TO ASSISTED DYING.

A 2012 Newspoll survey showed that 88% of Anglicans and 77% of Catholics agreed that a doctor should be allowed to meet a request from a hopelessly ill patient for help to die. While the hierarchy of the Catholic Church is opposed to voluntary assisted dying, it does not speak for the majority of Australian Catholics. A number of senior religious figures such as the former Archbishop of Canterbury Lord Carey and Archbishop Desmond Tutu have spoken out in support of the choice of assisted dying.

## MYTH

### DISABLED PEOPLE ARE OPPOSED TO ASSISTED DYING.

Many disabled people are not opposed to assisted dying. A number of well-known disabled people, including Professor Stephen Hawking, have spoken out in support of assisted dying legislation. <sup>13.</sup>

Disabled people would not be eligible for assistance to die under the Voluntary Assisted Dying Bill, unless they are terminally ill and meet all of the other eligibility criteria.

## MYTH

### THE MEDICAL PROFESSION IS OPPOSED TO ASSISTED DYING.

A recent survey showed that 60% of NSW doctors support the Voluntary Assisted Dying Bill and 80% of NSW nurses. <sup>14.</sup> This followed the AMA survey that showed 68% of doctors agree that 'there are patients for whom palliative care or other end of life care services cannot adequately alleviate their suffering'. <sup>15.</sup>

A key voice in the campaign for assisted dying is the nursing profession, with the national arm of the Australian Nursing and Midwifery Federation leading the lobbying effort.

*"As nurses we witness the suffering of patients and their families daily and we are seeking a law that gives people with a terminal illness, at the end stage of life, for whom there is no other option, the right to choose a peaceful death.*

ANMF Federal Secretary Lee Thomas



# 60%

of NSW doctors support the Voluntary Assisted Dying Bill.

# POLL RESULTS.

## Assisted Dying Opinion Poll Results – Australia

Public opinion in support of doctor-assisted dying has been in the majority for more than four decades. Support was in the high 60%<sup>s</sup> in the 1980s, in the mid to high 70%<sup>s</sup> in the 1990s, and in the low 80%<sup>s</sup> in the 2000/2010s.

Polling body	Date	Question	Yes	No
Newspoll	2007	Thinking now about voluntary euthanasia, if a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering asks for a lethal dose, should a doctor be allowed to provide a lethal dose, or not?	80%	14%
Newspoll	2009	Thinking now about voluntary euthanasia, if a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering asks for a lethal dose, should a doctor be allowed to provide a lethal dose, or not?	85%	10%
Australia Institute	2010	This question is about voluntary euthanasia. If someone with a terminal illness who is experiencing unrelievable suffering asks to die, should a doctor be allowed to assist them to die?	75%	13%
Newspoll	2012	Thinking now about voluntary euthanasia, if a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering asks for a lethal dose, should a doctor be allowed to provide a lethal dose?	82.5%	12.7%
Australia Institute	2012	This question is about voluntary euthanasia. If someone with a terminal illness who is experiencing unrelievable suffering asks to die, should a doctor be allowed to assist them to die?	71%	12%
ABC Vote Compass	2013	Terminally ill patients should be able to legally end their own lives with medical assistance.	75.1%	15.5%
Essential Media Communications	2014	When a person has a disease that cannot be cured and is living in severe pain, do you think should or should not be allowed by law to assist the patient to commit suicide if the patient requests it? <b>NB:</b> this poll used the term “commit suicide”, which is thought to be the reason for the lower than usual ‘Yes’ response	66%	14%
Ipsos Mori	2015	What do you think of doctor-assisted dying? Do you think it should be legal or not for a doctor to assist a patient aged 18 or over in ending their life, if that is the patient’s wish, provided that the patient is terminally ill (where it is believed that they have 6 months or less to live), of sound mind, and expresses a clear desire to end their life?	73%	15%
Essential Media Communications	2015	When a person has a disease that cannot be cured and is living in severe pain, do you think should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?	72%	12%
ABC Vote Compass	2016	Terminally ill patients should be able to legally end their own lives with medical assistance.	75%	16%

# MEDICAL PRACTICE.

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## MYTH

### **IF ASSISTED DYING WERE LEGALISED, IT WOULD BE SAFER TO REMOVE IT FROM MEDICAL PRACTICE SO THAT DOCTORS WOULD NOT BE REQUIRED TO KILL THEIR PATIENTS.**

If a request for assisted dying is approved, the dying person would administer the life-ending medication themselves. To use the word “kill” is therefore inappropriate.

Doctors are already required to make complex decisions about patients’ end-of-life care; this includes discontinuing futile treatment and respecting patients’ requests to refuse treatment, both of which may hasten death. Diagnosing a terminal illness, assessing mental capacity and providing palliative support and information all require the expertise of a suitably qualified professional.

Evidence from jurisdictions where assisted dying is legal shows that the model proposed in the Voluntary Assisted Dying Bill works. Doctors are best placed to effectively assess a request, removing them from the process would undermine the safeguards of the Bill.

According to the Australian Medical Association’s (AMA) latest survey, the majority of AMA doctors believe if assisted dying is legalised it should be provided by doctors. <sup>15</sup>

## MYTH

### **ASSISTED DYING IS CONTRARY TO MEDICAL ETHICS AND WOULD VIOLATE THE HIPPOCRATIC OATH.**

A long-standing tenet of the Hippocratic Oath is that doctors ‘do no harm’. It may be argued that to insist that a terminally ill patient who is experiencing unrelievable suffering must endure a ‘natural death’ is paternalistic, and has far greater potential for harm than to allow the patient to exercise autonomy over the manner and timing of their death. In contrast to the claim that assisted dying is a violation of the Hippocratic Oath, many healthcare professionals consider that being prevented from respecting the wishes of dying people is in conflict with their medical ethics.

A conscientious objection clause in the NSW Voluntary Assisted Dying Bill 2017 means no health provider, or other person, is under any duty to participate.

## MYTH

### **DOCTORS ARE NOT WILLING TO PARTICIPATE IN ASSISTED DYING SO A LAW WOULD NOT BE ABLE TO WORK IN PRACTICE.**

While 50% of AMA doctors who responded to their latest survey agreed that ‘doctors should not be involved in interventions that have as their primary purpose the ending of a person’s life, 52% agreed that ‘euthanasia’ can form a legitimate part of medical care and one in three doctors said they would provide voluntary assisted dying if requested, if it is legalised. <sup>15</sup>

Based on the experience from overseas, although there will be some doctors who will choose not to participate in assisted dying on moral or religious grounds, there will be enough doctors willing to participate. This will ensure that the health care sector can provide better outcomes for all Australians at the end of life, regardless of their treatment preferences.

**MYTH****ASSISTED DYING WOULD DAMAGE THE DOCTOR-PATIENT RELATIONSHIP.**

In Oregon, only 1 in 10 patients who discuss assisted dying with their doctor go on to take the life-ending medication <sup>16</sup>. Changing the law would allow a dying person to have honest, transparent conversations with their care team about their fears and wishes for the end of their life. Many would argue that the doctor-patient relationship is enhanced not damaged.

Emeritus Professor Ian Maddocks, Australia's most eminent palliative care physician, has said: "the existence of an assisted dying law would have made me a better palliative care physician."

**MYTH****DOCTORS CANNOT ACCURATELY PREDICT IF SOMEONE IS EXPECTED TO DIE WITHIN 12 MONTHS.**

Many doctors are experienced in assessing life expectancy. Evidence shows that errors in prognosis are more likely to be over-estimates of life expectancy. <sup>17</sup>. Data from the Oregon Health Authority tells us that only 7% of patients who receive the life-ending medication live for more than six months after being assessed as eligible for assistance. On average these patients outlive their prognosis by two months. <sup>18</sup>.

'Terminal' is already a legally recognised term in Australia. Australian insurance companies accept a prognosis of less than 12 months to live for the payout of a life insurance policy. This is a long-standing practice and is considered uncontroversial.

The assumption underlying concerns around prognosis is that patients are eager to die. This is not correct, as illustrated by the fact that in Oregon assisted dying patients wait an average of seven weeks between their first request and ingesting the life-ending medication. Additionally, around a third of patients who receive assisted dying do not take the life-ending medication, rather they die from their underlying illness. <sup>19</sup>.



# PALLIATIVE CARE.

## MYTH

### AN ASSISTED DYING LAW WILL NEGATIVELY IMPACT PALLIATIVE CARE.

Oregon, Washington and Vermont, which all have assisted dying legislation, are rated amongst the best states in the USA for the quality of palliative care. Ninety percent of patients who have an assisted death in Oregon are enrolled in hospice care. <sup>19.</sup>

The European Association of Palliative Medicine stated, after reviewing available evidence, that: "The idea that legalisation of euthanasia and/or assisted suicide might obstruct or halt palliative care development thus seems unwarranted and is only expressed in commentaries rather than demonstrated by empirical evidence." <sup>20.</sup>



**Of patients who have an assisted death in Oregon are enrolled in hospice care.**

## MYTH

### IF PALLIATIVE CARE IS IMPROVED THERE WILL BE NO NEED FOR ASSISTED DYING.

Palliative care in Australia is amongst the best in the world, so most Australians die well, however, even Palliative Care Australia acknowledges that: "It cannot relieve all pain and suffering, even with optimal care."

Suffering encompasses much more than just pain; loss of autonomy, being less able to engage in enjoyable activities and loss of dignity can deeply affect those at the end of their lives, but cannot necessarily be relieved by palliative care.

The Australian 'Palliative Care Outcomes Collaboration Report 2016' showed that of patients in the terminal phase of their illness, 4% had severe pain, 3% had severe psychological distress and 6.5% had other severe physical symptoms. <sup>21.</sup>

## MYTH

### A DIGNIFIED DEATH CAN BE ACHIEVED THROUGH PALLIATIVE SEDATION.

Not all terminally ill people view palliative sedation, which is essentially a medically-induced coma, as a satisfactory alternative to assisted dying. Many dying people want choice and control at the end of life, and to be able to communicate with loved ones as they approach their final moments.

Also, under the current law, decisions about when and at what speed palliative sedation is administered are entirely up to the treating doctor. If that doctor, or the institution, holds a core belief that assisting someone to die is killing them, the dying patient must face a slow death and they may experience significant suffering before this last resort treatment is commenced.

# THE NUMBERS.

## MYTH

### THE NUMBER OF ASSISTED DEATHS HAS INCREASED RAPIDLY IN STATES IN THE USA WHERE ASSISTED DYING IS LEGAL.

Claims that there have been significant increases in the number of people having an assisted death obscure the fact that when legislation is passed the number of people using the law is extremely low. In states in the USA where assisted dying is legal, assisted deaths account for approximately 0.4% of total deaths. <sup>4</sup>

While the raw numbers have increased, the percentage of overall deaths has remained consistent and very low. The reality is that overall deaths worldwide are increasing due to an aging population and the numbers of people being diagnosed with terminal cancer is also rising. Under assisted dying laws, no more people would die but fewer people would suffer at the end of their lives.

## MYTH

### THERE IS NO NEED TO CHANGE THE LAW FOR SUCH A SMALL NUMBER OF PEOPLE.

Although the number of assisted deaths would be relatively small, the number who take comfort from knowing the option is there is much higher. In Oregon 1 in 6 dying people speak openly about their options yet only 1 in 350 go on to request and take the life ending medication. <sup>22</sup>

1 IN 6



Dying people in Oregon speak openly to friends and family about whether assisted dying might comfort them.

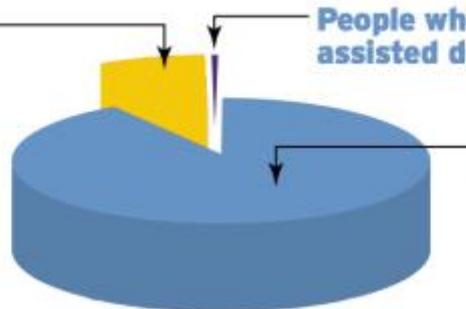
1 IN 350

Go on to request assisted dying and take the life-ending medication.

Dying people who speak openly to their friends and family about assisted dying

People who have an assisted death

Dying people in Oregon



# INCREASING ACCESS TO ASSISTED DYING.

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## Increasing access to legal assisted dying



## CONCLUSION.

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Dying With Dignity NSW supports the recommendation that followed the Victorian Inquiry Into End Of Life Choices, that assisted dying should be incorporated into existing end of life care processes in order to protect and support patients and ensure sound medical practice.

The needs of the patient must be squarely at the centre of an effective framework and ensuring that the rights of patients are respected depends on the expertise and judgment of those working within the framework, particularly doctors.

We support this statement by Emeritus Professor Ian Maddocks AM, who is considered the father of palliative care in Australia:

*"Rather than fighting a rear-guard action, I suggest the proponents of palliative care join forces with advocates of assisted dying, and with mutual respect and dialogue ensure that enabling laws are framed with a care and precision that allows no abuse and promotes best outcomes."* <sup>2</sup>

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**Dying with Dignity**   
New South Wales

**ASSISTED DYING:**  
**SOME**  
**FREQUENTLY**  
**ASKED**  
**QUESTIONS?**



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# INTRODUCTION.

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On Thursday 21 September, the Hon. Trevor Khan MLC, introduced the Voluntary Assisted Dying Bill 2017 in the Legislative Council on behalf of the NSW Parliamentary Working Group on Assisted Dying. The Voluntary Assisted Dying Bill has been prepared over the past two years by the cross-party working group, consisting of the Hon. Trevor Khan MLC (Nationals), Dr. Mehreen Faruqi MLC (Greens), the Hon. Lynda Voltz MLC (Labor), Lee Evans MP (Liberals) and Alex Greenwich MP (Independent).

The Working Group has consulted extensively since 2015 with key stakeholder organisations and NSW parliamentarians on the Bill. Since the release of the Exposure Draft in May 2017, the Working Group assessed more than 70 substantive submissions and made a number of key improvements to the Bill. The Working Group has also hosted community information sessions in collaboration with Dying with Dignity NSW and other organisations and parliamentarians across Sydney and key regional centres of NSW.

If passed, the Voluntary Assisted Dying Bill 2017 will allow terminally ill people, who meet strict eligibility criteria to request and receive assistance to die at the end of their life to avoid prolonged and unbearable suffering.

Dying with Dignity NSW has been the key advocacy group lobbying for this law reform for over 50 years. We believe that in the face of unrelievable suffering from a terminal illness, the ability to choose the manner and timing of one's death should be a basic human right. It is a right that is already available in many jurisdictions around the world, including Switzerland, the Netherlands, Belgium, Luxembourg, Germany, Canada, Colombia as well as six American States and the District of Columbia, which includes the nation's capital, Washington D.C.

In order to assist parliamentarians during their decision-making process in the lead up to the debate, we have put together two documents:

*'Assisted Dying: Setting the Record Straight'* dispels the common 'myths' being promoted by opponents of assisted dying.

*'Assisted Dying: Some Frequently Asked Questions'* aims to provide answers to many of the questions raised during this debate.

## **AUSTRALIANS DESERVE A DIGNIFIED, RESPECTFUL AND EVIDENCE-BASED DEBATE ABOUT ASSISTED DYING.**

We encourage all members of the NSW Parliament to examine the evidence and base their decisions on facts, not fear.

Terminally ill people deserve the compassion and protection of a robust law, with strict safeguards. They also deserve an informed, evidence-based debate when lawmakers are determining what end-of-life choices should be available to them.

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## Voluntary Assisted Dying Bill 2017 (NSW) – An Overview

The NSW Parliamentary Working Group on Assisted Dying prepared this overview.

### Eligibility under the Voluntary Assisted Dying Bill 2017 (NSW)

The Bill establishes a framework for certain terminally ill persons to request and receive assistance to end their lives voluntarily. To be eligible, a patient must be:

- *At least 25 years of age, an Australian citizen or a permanent resident, and ordinarily live in New South Wales,*
- *Suffering from a terminal illness with a 12-month prognosis, and*
- *Experiencing severe pain, suffering or physical incapacity.*

At any time and in any manner the patient will be able rescind a request for assistance.

### Framework under the Voluntary Assisted Dying Bill 2017 (NSW)

To receive assistance, eligible patients must be assessed by:

- *A primary medical practitioner,*
- *A secondary medical practitioner who is a specialist in the patient's terminal illness, and*
- *A psychiatrist or clinical psychologist to confirm the patient has decision-making capacity, and is making a free, voluntary and considered decision.*

The primary medical practitioner must provide the patient written information about: the nature of the illness and its likely course; medical treatment available, including palliative care, counselling and psychiatric support; measures for keeping the patient alive; and the patient's right to rescind a request.

The primary medical practitioner must offer to refer a patient who requests assistance to a palliative care specialist. The patient is not required to accept the offer of referral.

The patient, primary medical practitioner, secondary medical practitioner, and psychiatrist or psychologist will need to sign a certificate confirming that eligibility requirements have been met before assistance is provided. The patient cannot sign the certificate until seven days have passed since they made the initial request for assistance and a further 48 hours must pass after the certificate is completed before the primary medical practitioner can prescribe the lethal substance.

The patient must self-administer the lethal substance, however if the patient is physically unable to self-administer, the primary medical practitioner or a designated doctor or nurse can administer the substance. The lethal substance must be an authorised substance set out in the regulations. A patient is under no obligation to actually administer after having gone through the process.

### Additional protections under the Voluntary Assisted Dying Bill 2017 (NSW)

Medical practitioners, health facilities, and health care providers reserve the right to conscientiously object to being involved in providing someone assistance.

The Bill establishes a framework for judicial review by the Supreme Court. Close relatives of the patient may request the Supreme Court to make an order to make the request certificate not effective on the grounds that the patient does not satisfy the eligibility criteria or did not possess decision-making capacity, or that the patient's request was not made freely, voluntarily and after due consideration.

The Bill establishes a Voluntary Assisted Death Review Board that will review each assisted death under the Act. The Review Board will also monitor the scheme, refer breaches to authorities, conduct research, make recommendations, and report to Parliament and the public.

# TERMINOLOGY.

## QUESTION

### WHAT IS VOLUNTARY ASSISTED DYING?

Voluntary assisted dying (VAD) is a quick and peaceful death which results from a patient taking, or administering to themselves, a fatal dose of a medication. It involves a medical practitioner making the lethal substance available to an eligible patient (after having gone through a highly-safeguarded, medical assessment process), which the patient then uses to end their life at a time and place of their choosing. The patient is in control at all stages of the process.

## QUESTION

### WHAT IS THE DIFFERENCE BETWEEN VOLUNTARY ASSISTED DYING AND VOLUNTARY EUTHANASIA?

**Voluntary Assisted Dying (VAD)** and **Voluntary Euthanasia (VE)** are often used in common language to mean the same thing. However, they are actually defined differently. The difference is that in the case of VAD, the lethal medication is self-administered, whilst in the case of VE, the lethal medication is administered by someone else, usually a doctor giving a lethal injection.

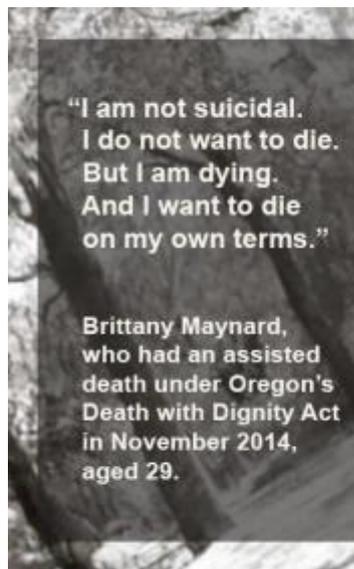
Currently, both voluntary euthanasia and voluntary assisted dying are illegal in Australia.

NB: Both the NSW and the Victorian Voluntary Assisted Dying Bills are based on the conservative and narrow Oregon model, not voluntary euthanasia per the broader European models. Both the NSW and the Victorian Voluntary Assisted Dying Bills would allow assistance to die by self-administration only (i.e. voluntary assisted dying), with the only exception being administration of the lethal drug by the doctor (i.e. voluntary euthanasia) where the terminally-ill person is physically unable to self-administer the lethal drug.

## QUESTION

### WHY IS THE TERM 'ASSISTED SUICIDE' NOT APPROPRIATE?

Dying people who want to control the manner and timing of their death are not suicidal. Oregon's Death with Dignity Act itself states that a death under its provision is not a suicide — there being major differences between a rational and fully informed choice in the face of intolerable and unrelievable end-of-life symptoms, and irrational choices about transient problems. <sup>1</sup>.



# PUBLIC SUPPORT.

## QUESTION

### HOW MANY AUSTRALIANS SUPPORT VOLUNTARY ASSISTED DYING?

A recent poll commissioned by Dying with Dignity NSW and conducted by Essential Research<sup>2</sup>, confirmed the results of a 2015 Ipsos Mori poll.<sup>3</sup> Both polls showed that:

**73% OF AUSTRALIANS**

**SUPPORT THE CHOICE OF ASSISTED DYING FOR TERMINALLY ILL PEOPLE**

**AND ONLY 15% OPPOSE** <sup>2</sup>.

## QUESTION

### DO OLDER AUSTRALIANS SUPPORT VOLUNTARY ASSISTED DYING?

The Essential Research survey also showed that support for assisted dying rose to 81% for people aged 55 years or over, with only 10% in that age group being opposed.<sup>2</sup>

## QUESTION

### HOW MANY NSW VOTERS SUPPORT VOLUNTARY ASSISTED DYING?

A recent ReachTEL Poll commissioned by Fairfax Media in October 2017 has found 'an overwhelming majority of NSW residents support a law that would give the terminally ill the right to end their lives with a doctor's assistance'.

The poll revealed more than 87 per cent of Nationals voters supported the question, about 61 per cent of Liberals voters and 73 per cent of Labor voters.

About 18 percent of voters said they were undecided on the question and only 13 per cent said they were opposed or strongly opposed.<sup>4</sup>



Approximately

**70%**

**of NSW voters support voluntary assisted dying.**

## QUESTION

### HOW MANY DOCTORS AND NURSES SUPPORT VOLUNTARY ASSISTED DYING?

A recent survey showed that 60% of NSW doctors support the NSW Voluntary Assisted Dying Bill and 80% of NSW nurses.<sup>2</sup> This followed the AMA's survey that showed 68% of doctors agree that 'there are patients for whom palliative care or other end of life care services cannot adequately alleviate their suffering'.<sup>6</sup>

A key voice in the campaign for assisted dying is the nursing profession, with the NSW Branch of the Australian Nursing and Midwifery Federation leading the lobbying effort.

*"This is a very important issue for the nursing profession. Given our compassion for those who suffer and our concern for quality of life being afforded to every individual, this is an issue worth fighting for to ensure the right balance is achieved and all sides of the debate are well considered."*<sup>7</sup>

NSWANMF President, Coral Levett



# 60%

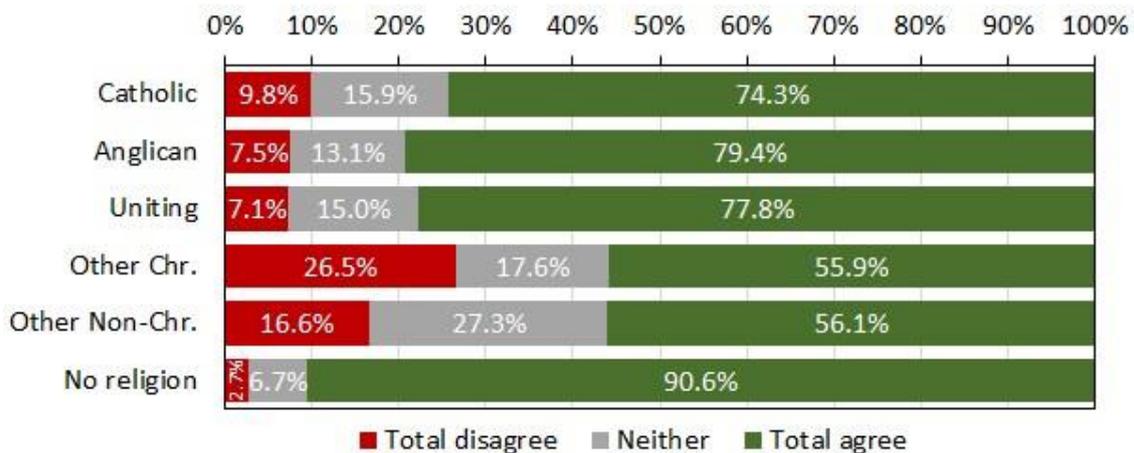
of NSW doctors support the Voluntary Assisted Dying Bill.

## QUESTION

### IS VOLUNTARY ASSISTED DYING SUPPORTED BY PRACTISING CHRISTIANS?

Many Christians believe that voluntary assisted dying, is consistent with Christian values and with Jesus' message of love and compassion, especially for those who are suffering. Today the overwhelming majority of Australian Christians support choice for voluntary assisted dying. A number of studies have confirmed that whilst support for voluntary assisted dying is strongest amongst those who say they have no religion, the vast majority of religious Australians are also supporters.

For example, the 2016 Australian Election Study (AES), conducted by scholars at Australian National University, found support for the statement that, "Terminally ill people should be able to legally end their own lives with medical assistance" for 74.3% of Catholics and 79.4% of Anglicans, 77.8% of Uniting Church and 90.6% for those with no religion.<sup>8</sup>



It is evident that the Catholic Church and members of the clergy who publicly oppose voluntary assisted dying are not representing the view of their 'flock'.

The Australian organisation, *Christians Supporting Choice for Voluntary Euthanasia*, has an excellent website which sets out the arguments and closely examines Christian doctrine in relation to the question of voluntary assisted dying.

# DOCTORS' SUPPORT.

## QUESTION

### ARE THERE DOCTORS WHO SUPPORT VOLUNTARY ASSISTED DYING?

Although the current federal president of the Australian Medical Association, Dr Michael Gannon, is personally and publicly opposed to assisted dying law reform, the membership of the Australian Medical Association is split. <sup>6</sup>

Professor Brian Owler, neurosurgeon and the immediate past federal president of the Australian Medical Association, gave an address to the National Press Club on 12 October 2017, speaking in support of voluntary assisted dying.

Amongst other things, Professor Owler said:

*"Voluntary assisted dying is not about a choice between life and death. No. Rather, it is about respect for a dying person's choice, about the timing and manner of their death."*

*"The need for this legislation is plainly evident. Many of those most determined to see this law pass have personal anecdotes of loved ones whose death has been terrible. Not only was the person's suffering prolonged and unbearable but it left deep lingering wounds in the hearts of their family and friends. The impact and depth of those wounds should never be discounted."*

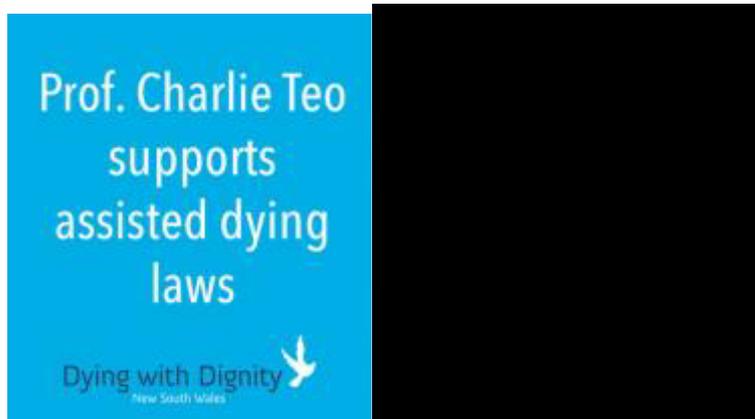
In closing, Professor Owler spoke directly to members of the Victorian Parliament, as they prepare to vote on their own assisted dying legislation, however, he could just as easily be addressing members of the NSW Parliament. He said:

*"I know that all of you went into Parliament to make a difference. As a doctor, I understand this desire. It's what motivates doctors as well. For some of you, this may be one of the hardest decisions you make in your political career. But to be able to make a decision, the result of which is to ease the suffering of a person who is dying, and those who love that person, to provide them with the comfort of a choice, not just for one day but for days into the future, that is a unique opportunity for our parliamentarians to exercise. This is an opportunity not to be wasted." <sup>9</sup>*

There are many other doctors who are speaking up in support of voluntary assisted dying, including those who are members of a national organisation called *Doctors for Assisted Dying Choice*.

The latest high profile doctor to support voluntary assisted dying laws is Professor Charlie Teo. In a recent Facebook post for Dying with Dignity, Prof Charlie Teo said:

*"I am proud of my reputation of never giving up on patients who still have the will to live despite what others believe to be an exercise in futility. I am equally as proud to support Dying with Dignity because the only situation that would be worse than not having control of your life is to not have control over your own death."*



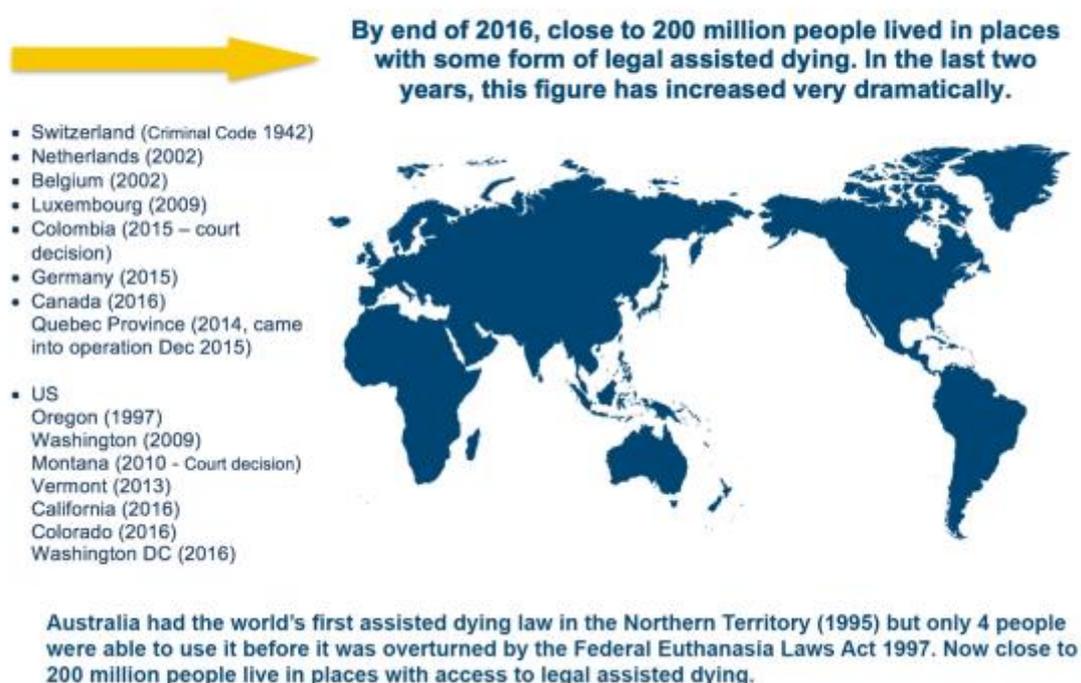
# THE LAWS OVERSEAS.

## QUESTION

### WHICH OTHER COUNTRIES HAVE LEGALISED VOLUNTARY ASSISTED DYING OR VOLUNTARY EUTHANASIA?

There are currently 14 international jurisdictions that provide access to either voluntary assisted dying or voluntary euthanasia, for those people who meet strict eligibility criteria within robust legal frameworks.

### Increasing access to legal assisted dying



## QUESTION

### HOW DO THE LAWS DIFFER AROUND THE WORLD?

There are differences between the various laws in regard to the eligibility criteria, the method of administration of the lethal medication and the legal framework, or process.

The American laws (on which the Australian laws are based) are considered the most restrictive, because the individual has to be suffering from a terminal illness, with less than 6 months to live, whereas the European laws do not restrict access based on a terminal illness. In Europe, the eligibility and safeguards are based on a model requiring 'due care' on the part of the doctor assisting a patient to die and the patient must be experiencing 'unbearable and irremediable suffering' to qualify.

The American laws require self-administration only, whereas under the European and Canadian models, both voluntary assisted dying and voluntary euthanasia are permitted.

Space in this booklet does not allow for a detailed comparison of the legal frameworks, safeguards and procedures involved in the various assisted dying models around the world. However, according to the Victorian Committee, which travelled to many of these

jurisdictions, although the models differ, 'what they all have in common is robust regulatory frameworks that focus on transparency, patient-centred care and choice.' The Committee found no evidence of institutional corrosion or the often cited 'slippery slope'<sup>10</sup>.

## QUESTION

### HAVE THE ASSISTED DYING LAWS OVERSEAS BEEN BROADENED OVER TIME?

As explained above, the eligibility criteria in the European and American laws has always been different. Out of the 14 jurisdictions that have legalised either voluntary assisted dying or voluntary euthanasia, only one jurisdiction has made an amendment to their law, all the others have remained unchanged. The only jurisdiction to have amended its law is Belgium, when in 2014, twelve years after legalising voluntary euthanasia, it amended the rules to permit doctor-assisted death for minors in a hopeless medical situation and with their explicit consent. <sup>11</sup>.

NB. The Australian laws are based on the Oregon law that has remained unchanged for 20 years and only applies to competent, terminally ill adults.

## QUESTION

### CAN PEOPLE WITH MENTAL ILLNESS OR A DISABILITY QUALIFY UNDER THE OVERSEAS LAWS?

Under the American laws, (on which the NSW and Victorian Bills are based), eligibility criteria are based on the diagnosis of a terminal illness, not on a disability, so having a disability alone does not meet the eligibility criteria. However, if someone with a disability, meets the eligibility criteria because for instance of a cancer, they would not be denied access to voluntary assisted dying so long as they satisfy all of the eligibility criteria on the basis of their cancer. The same applies to mental illness. Although a person with mental illness alone would not meet the eligibility criteria for voluntary assisted dying, they would not be discriminated against because they had a mental illness but otherwise met all of the eligibility criteria unless the mental illness impairs decision-making capacity in relation to voluntary assisted dying.

As explained earlier, the eligibility criteria in the European model allows someone with 'unbearable and irremediable suffering' to request an assisted death. This means it is possible for someone with a mental illness, or a severe disability, to qualify if they have decision-making capacity and all the safeguards are met, including that the physician is satisfied that the patient's suffering is unbearable, with no prospect of improvement.

Although it is possible under their law, the numbers of people qualifying with a mental illness, or disability, are quite small. The vast majority of people accessing assisted dying in Europe are the same as those in America and Canada, that is, people dying of terminal, physical illnesses such as cancer, or MND.

## QUESTION

### CAN CHILDREN REQUEST ASSISTED DYING IN JURISDICTIONS WHERE IT IS LEGAL?

Under the American and Canadian laws, only competent adults aged 18 years or over can qualify, if they meet all other eligibility criteria. In Europe, the laws do allow access for some minors, however, the safeguards are stricter and only a very small number of children have accessed their assisted dying laws. In the Netherlands between 2002 and 2015 only 7 children have had an assisted death. In Belgium, it was two years after the law was amended in 2014, before the first minor accessed an assisted death. He was 17-year-old and he died in mid 2016. <sup>11</sup>. In Belgium, for a minor to undergo voluntary euthanasia, they must be in a 'terminal medical situation with constant and unbearable physical pain which cannot be assuaged and that will cause death in the short term.' <sup>11</sup>.

NB. Under the NSW Bill the terminally ill patient must be at least 25 years of age.

# PALLIATIVE CARE.

## QUESTION CAN PALLIATIVE CARE RELIEVE THE PAIN AND SUFFERING OF DYING AUSTRALIANS?

Australia has one of the best palliative care systems in the world and it has improved significantly over the past 20 years. For the majority of dying Australians, palliative care can relieve the complex mixture of physical, emotional and psychological symptoms, however, it cannot relieve all pain and suffering.

## QUESTION WHAT PERCENTAGE OF DYING PATIENTS CAN'T HAVE THEIR SUFFERING ALLEVIATED?

Based on data collected by approximately 100 palliative care services across Australia every year, we know that a small yet significant percentage of dying patients cannot have their symptoms controlled, even with the best efforts of palliative care.

The most recent Australian 'Palliative Care Outcomes Collaboration Report 2016' includes numerous tables documenting relevant data. Table 1 - 'Benchmark Summary' shows that a realistic goal for 'moderate to severe pain, becoming absent or mild' was only 60% and yet this benchmark was not achieved.<sup>12</sup> The benchmark for 'moderate to severe breathing problems, becoming absent or mild' was also 60%, yet this outcome was only achieved for 46.6% of patients in inpatient services and 35.8% of patients using community palliative care services.<sup>12</sup> Even if palliative care services reached their current benchmarks, there would still be a large number of patients whose pain or suffering was unable to be alleviated.

### Section 1 Benchmark summary

Table 1 Summary of outcome measures by setting

Description	Benchmark	Inpatient %	BM Met?	Community %	BM Met?	
Outcome measure 1 – timely admission to service						
Patients episode commences on the day of, or the day after date ready for care (BM1)	90%	97.2	Yes	87.4	No	
Outcome measure 2 – responsiveness to urgent needs						
Patients in the unstable phase for 3 days or less (BM2)	90%	89.0	No	80.5	No	
Outcome measure 3 – change in symptoms and problems						
Pain (clinician rated)	Absent or mild pain, remaining absent or mild (PCPSS, BM3.1)	90%	91.5	Yes	85.7	No
	Moderate or severe pain, becoming absent or mild pain (PCPSS, BM3.2)	60%	59.9	No	54.9	No
Pain (patient rated)	Absent or mild distress from pain, remaining absent or mild (SAS, BM3.3)	90%	89.5	No	82.5	No
	Moderate or severe distress from pain, becoming absent or mild (SAS, BM3.4)	60%	55.4	No	49.3	No
Fatigue (patient rated)	Absent or mild distress from fatigue, remaining absent or mild (SAS, BM3.5)	90%	85.4	No	70.5	No
	Moderate or severe distress from fatigue, becoming absent or mild (SAS, BM3.6)	60%	47.0	No	26.5	No
Breathing problems (patient rated)	Absent or mild distress from breathing problems, remaining absent or mild (SAS, BM3.7)	90%	94.8	Yes	91.5	Yes
	Moderate or severe distress from breathing problems, becoming absent or mild (SAS, BM3.8)	60%	46.6	No	35.8	No
Family / carer problems (clinician rated)	Absent or mild family / carer problems, remaining absent or mild (PCPSS, BM3.9)	90%	90.7	Yes	81.8	No
	Moderate or severe family / carer problems, becoming absent or mild (PCPSS, BM3.10)	60%	46.4	No	42.6	No
Outcome measure 4 – case-mix adjusted outcomes (X-CAS)						
Clinician rated (PCPSS)	Pain (BM4.1)	0.0	0.10	Yes	-0.07	No
	Other symptoms (BM4.2)	0.0	0.21	Yes	-0.06	No
	Family / carer (BM4.3)	0.0	0.13	Yes	-0.03	No
	Psychological / spiritual (BM4.4)	0.0	0.16	Yes	-0.06	No
Patient rated (SAS)	Pain (BM4.5)	0.0	0.32	Yes	-0.23	No
	Nausea (BM4.6)	0.0	0.21	Yes	-0.11	No
	Breathing problems (BM4.7)	0.0	0.29	Yes	-0.07	No
	Bowel problems (BM4.8)	0.0	0.23	Yes	-0.01	No

National Report on Patient Outcomes in Palliative Care in Australia, January - June 2016, detailed report

Table 31 from the same report shows that the percentage of patients experiencing severe pain can be as high as 10.3% in the unstable phase. Even for patients in the terminal phase of their terminal illness (usually the last two days of life), 3.6% had severe pain, 3% had severe psychological distress and 6.5% had other severe physical symptoms.<sup>12.</sup>

**Table 31 Profile of PCPSS at beginning of phase by phase type – inpatient setting (percentages)**

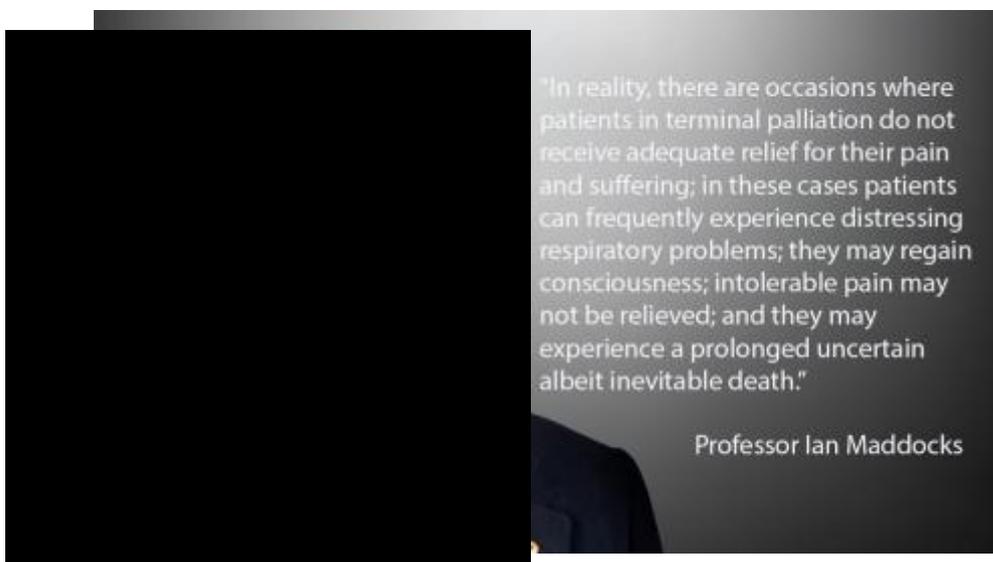
Phase type	Problem severity	Absent	Mild	Moderate	Severe
Stable	Pain	49.6	38.7	9.9	1.8
	Other symptoms	32.8	51.0	13.9	2.3
	Psychological / spiritual	43.9	45.9	8.6	1.6
	Family / carer	47.6	41.1	9.2	2.1
Unstable	Pain	30.9	33.7	25.1	10.3
	Other symptoms	17.8	39.4	31.6	11.1
	Psychological / spiritual	28.7	47.7	18.8	4.8
	Family / carer	31.0	45.2	18.2	5.7
Deteriorating	Pain	39.1	39.1	17.1	4.7
	Other symptoms	22.8	44.8	26.5	5.9
	Psychological / spiritual	36.0	46.5	14.6	3.0
	Family / carer	33.3	43.7	17.9	5.1
Terminal	Pain	49.1	34.1	13.3	3.6
	Other symptoms	40.3	35.7	17.5	6.5
	Psychological / spiritual	57.0	31.3	8.7	3.0
	Family / carer	28.2	39.6	23.5	8.7

**QUESTION**

**ISN'T TERMINAL SEDATION AN OPTION WHEN PAIN OR SUFFERING CANNOT BE RELIEVED?**

Terminal or palliative sedation is a last resort option, if a patient is experiencing intolerable and unrelievable suffering. However, as the Victorian Inquiry found 'doctors take differing approaches to continuous palliative sedation, including how deeply and quickly sedation should be administered.'<sup>10.</sup> As a result, not all patients will receive sedation to a level where their pain or suffering is alleviated.

Yet even terminal sedation doesn't guarantee a peaceful death. As Australia's most senior palliative care physician, Professor Ian Maddocks, explains:



# CURRENT PRACTICES.

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## QUESTION

### ARE DOCTORS CURRENTLY ASSISTING THEIR PATIENTS TO DIE?

As the practice of assisted dying is currently illegal, there are significant impediments to accurately quantifying the extent to which these practices occur in Australia. However, research over many years has shown that some medical professionals are already assisting some of their patients to die but it is happening covertly, irregularly and usually at an advanced stage of illness (often hastening death by a week or two).<sup>13</sup>

## QUESTION

### IF ASSISTED DYING IS ALREADY HAPPENING, WHY CAN'T WE LEAVE THINGS AS THEY ARE?

According to the findings of the Victorian Inquiry into End of Life Choices, 'existing end of life care legislation is confusing in many ways, and causes uncertainty, particularly for health practitioners.'<sup>10</sup> This legal uncertainty can lead to under-medicating for fear of criminal liability for hastening a patient's death. This confusion and uncertainty can affect dying patients and their families and lead to unnecessary and prolonged suffering and that is why we shouldn't leave things as they are.

Although there are some doctors who have actually provided lethal medication to dying patients, very few are willing to admit to it publicly (Dr Rodney Syme is one exception). Because this practice has to be done covertly, a dying patient seeking the option of a peaceful death would find it very difficult to find doctors like Dr Syme.

Some people consider the practice of palliative sedation to be a form of 'assisted dying'. However, as the Victorian Inquiry found, because 'doctors take differing approaches to continuous palliative sedation, including how deeply and quickly sedation should be administered'<sup>10</sup>, it means not all patients will have all their suffering alleviated.

Whether it is the provision of lethal medication or the provision of terminal sedation, because these practices are not regulated, there are no safeguards or monitoring and the ongoing unlawful practice of assisted dying brings the law into disrepute.

## QUESTION

### WILL AN ASSISTED DYING LAW CHANGE THE DOCTOR PATIENT RELATIONSHIP?

An assisted dying law may change the doctor patient relationship, however, evidence shows it is likely to be a positive change. Under an assisted dying framework, the paternalism encouraged by our existing laws is likely to be replaced by a partnership. Instead of doctors deciding unilaterally how much, or how little, or how quickly, a dying person should have their suffering relieved, it becomes a conversation between the doctor and that dying individual.

Assisted dying laws make it possible for honest conversations to start early after a terminal diagnosis. Patients can have these conversations with their doctors but also with family members and their dying can be managed in a rational and humane way. Providing this level of control has a significant palliative effect in itself.

According to a recent report from California, one year after their law was introduced, 'physicians across the state say the conversations that health workers are having with patients are leading to patients' fears and needs around dying being addressed better than ever before. They say the law has improved medical care for sick patients, even those who don't take advantage of it.'<sup>14</sup>

# CHANGING THE LAW.

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## QUESTION

### WHAT LEGAL OPTIONS DOES A DYING PATIENT HAVE UNDER THE CURRENT LAW?

Under the current law, if a dying individual is experiencing unbearable and unrelievable suffering, they have just three legal options:

- They can commit suicide, but this is a lonely, desperate and often violent option.
- They can end their own life by refusing all medical treatment, including food and water, and basically starve and dehydrate to death, but this is usually a long and psychologically painful process for the patient and their family.
- The third legal option can occur after a dying patient has been suffering for some time. If their suffering has become unbearable and unrelievable, their doctor can slowly put them into a coma – even without their consent – leaving them to die over days, or sometimes weeks. As discussed earlier, this is called 'terminal or palliative sedation', but there is a lot of suffering that has to be experienced before this last resort option is taken and it can be distressing for all involved.

## QUESTION

### WHY DO WE NEED TO INTRODUCE AN ASSISTED DYING LAW?

The Victorian Inquiry into End of Life Choices recommended introducing an assisted dying law because, after gathering evidence over a 10-month inquiry, they found:

- Existing Australian laws relating to end of life care are confusing and cause uncertainty, particularly for health practitioners.
- The current illegality of assisted dying can cause great pain and suffering for those who endure terminal illnesses.
- Repeated examples of inadequate pain relief being delivered to dying patients by doctors for fear of breaking the law.
- An inability of palliative care, despite its many benefits, to relieve all suffering.
- Although courts impose lenient penalties without jail time on people who do assist loved ones to end their lives, the potential burden of a court battle compounds carers' distress and grief.
- Doctors being forced to break the law in order to help their patients die, but having to do so without support, regulation, or accountability.
- Trauma experienced by families watching seriously ill loved ones' refuse food and water to expedite death and finally relieve their suffering.
- People experiencing an irreversible deterioration in health taking their own lives, often in horrific circumstances.

In its conclusion, the Committee rejected maintaining the status quo as 'an inadequate, head-in-the-sand approach to policy making' and the plight of the Australians discussed in their report. They recommended a law that would allow people to seek assistance to die. In their words, this would: 'not only enable patients end of life wishes to be respected, but also to protect patients, particularly vulnerable people, from abuse and coercion'.

The Committee also found strongly in favour of increased resources and funding for palliative care. In so doing, they made it abundantly clear that assisted dying and palliative care were both important points on the spectrum of end of life care in general.

# THE PROPOSED LAW.

## QUESTION

### WHAT SORT OF PEOPLE WILL ACCESS THE VOLUNTARY ASSISTED DYING LAW?

Assisted dying laws are introduced to help a very particular, very small, group of people. They are individuals who are dying and who are experiencing unbearable and unrelievable suffering at the end stage of their terminal illness. Based on similar laws that have operated in America for 20 years, we can predict that they will be primarily dying from cancer (79%), progressive diseases such as Motor Neurone Disease (7%) and heart disease (7%).

## QUESTION

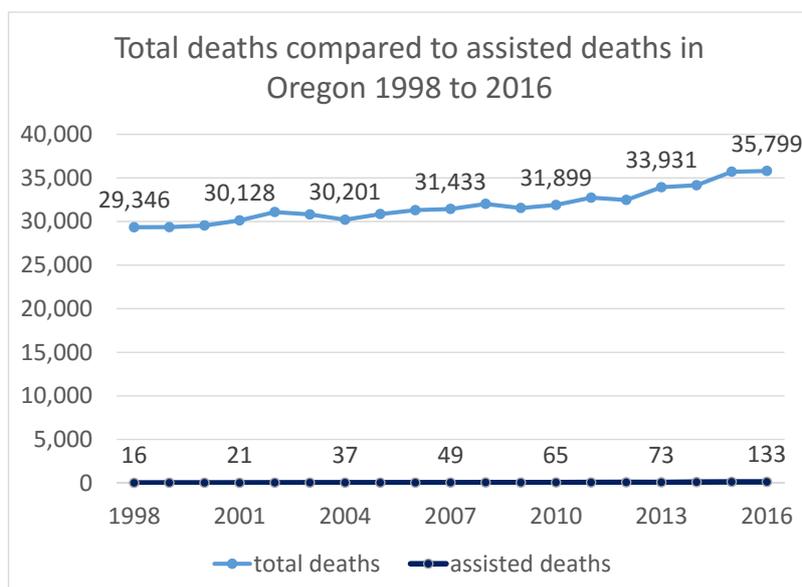
### WILL THE DISABLED BE ABLE TO ACCESS THE VOLUNTARY ASSISTED DYING LAW?

It is important to remember that the eligibility criteria are based on the diagnosis, not on a disability, therefore having a disability alone does not satisfy the eligibility criteria. However, if someone with a disability meets the eligibility criteria because for instance they have terminal cancer, they would not be denied access to voluntary assisted dying so long as they satisfy all of the eligibility criteria because of their cancer.

## QUESTION

### HOW MANY PEOPLE ARE LIKELY TO USE THE VOLUNTARY ASSISTED DYING LAW?

The number of people choosing to access voluntary assisted dying are likely to be small. Based on the evidence from Oregon, voluntary assisted dying deaths are likely to account for less than half of one percent of all deaths. Even in Europe where the eligibility criteria are much broader than the American model and the NSW VAD Bill, the total number is between 2-4% of all deaths.



## QUESTION

### WHY IS THE PROGNOSIS SPECIFIED AS BEING 12 MONTHS OR LESS TO LIVE?

In line with the recommendation of the Victoria Ministerial Advisory Panel, the NSW PWGAD found merit in the incorporation of a 12-month timeframe. 'This timeframe is consistent with existing end of life policy documents including the *National Consensus Statement on essential elements for safe and high-quality end-of-life care.*' <sup>15</sup>.

Also as Professor Brian Owler explained in a recent address to the National Press Club, the 12-month outer-limit is there for two main reasons. 'First it provides clarity and certainty for those individuals who want to access voluntary assisted dying and their assessing doctors. Second, it provides allowance for diseases with longer time courses such as motor neurone disease who may otherwise find it difficult to access voluntary assisted dying. We felt that it was very important that this group not be excluded.'<sup>9</sup>

## QUESTION

### WHAT IF A PATIENT CHOOSES TO DIE EARLY, WON'T THAT MEAN THEY COULD MISS OUT ON QUALITY TIME WITH FAMILY AND FRIENDS?

Despite a terminal diagnosis, people fight to stay alive. Under the NSW Voluntary Assisted Dying Bill, in order to access assisted dying, the dying individual not only has to have a prognosis of 12 months or less, they also have to be experiencing 'severe pain, suffering or incapacity' before they would qualify for an assisted death. Based on the overseas evidence, most patients will make good use of palliative care right up until they can no longer tolerate their suffering. At that point, they may decide to take the medication and it is usually in the last days or weeks of their life.

## QUESTION

### WHAT ARE THE KEY SAFEGUARDS IN THE VOLUNTARY ASSISTED BILL?

- 1) To be eligible, the patient must be:
  - a. at least 25 years of age, an Australian citizen or a permanent resident, and ordinarily live in New South Wales;
  - b. suffering from a terminal illness that in reasonable medical judgement will result in death within 12 months; and
  - c. experiencing severe pain, suffering or physical incapacity.
- 2) The patient must be assessed by two medical practitioners (one of whom must be a specialist for the relevant terminal illness) to both conclude that the patient's illness is terminal and that they will likely die within 12 months, that the illness is causing severe pain, suffering or physical incapacity and that there is no cure.
- 3) The patient must be assessed by a psychiatrist or clinical psychologist who must conclude that the patient has decision-making capacity and has made their request for assistance freely, voluntarily and after due consideration.
- 4) The medical practitioners and the psychologist or psychiatrist cannot be related to the patient or a beneficiary of his or her will, and they cannot be from the same medical practice.
- 5) The patient and assessing doctors will need to sign a certificate before assistance can be provided. At least seven days must pass between when the patient first requests assistance and signs the certificate, and then another 48 hours must pass after the certificate is complete before assistance can be provided.
- 6) Doctors and health care providers are not required to participate in any way and can withdraw from any arrangement to provide assistance at any time.
- 7) Close relatives of the patient will be able to apply to the Supreme Court for an injunction on assistance on the grounds that the patient does not satisfy the eligibility criteria or, did not have decision-making capacity, or that their request was not made freely, voluntarily and after due consideration.
- 8) The patient must receive extensive written medical information about their illness and their request for assistance and must be offered a referral for a palliative care consultation.
- 9) A Voluntary Assisted Death Review Board will review each death under the Act, monitor the scheme, refer breaches to the authorities, make policy recommendations, conduct research and report to the government, Parliament and the public.
- 10) The State Coroner will review each death under the Act.

# THE ARGUMENTS.

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## QUESTION

### WHAT ARE THE MAIN ARGUMENTS IN SUPPORT OF VOLUNTARY ASSISTED DYING?

Most advocacy organisations, both here and overseas, have websites that list the main arguments in support of voluntary assisted dying. However, because the Victorian Parliamentary Inquiry into End of Life Choices was the most comprehensive inquiry of its kind ever held in Australia, and its findings would apply to every state and territory, we have chosen to use the summary that was included in their Final Report. <sup>10</sup>

#### AUTONOMY

This argument states that each person has the right to determine the course of their life in keeping with their values and beliefs, within the limits imposed by the rights and freedoms of others.

This autonomy, or self-determination, is fundamental to liberal democracy and the common law. Further, autonomy is a basic principle of medical ethics. It entitles patients to choose a preferred medical intervention or refuse treatment, and should also give a person the right to choose the time and manner of their own death.

This argument has also been framed by saying the state does not have the right to diminish the individual's autonomy in choosing assisted dying, as it does no harm to others.

The autonomy argument often includes reference to 'choice', or 'control'. A common argument relating to control is that simply having the option to choose assisted dying has a palliative effect in and of itself by enabling people at the end of life to reclaim control of their situation.

#### RELIEF FROM SUFFERING – PATIENTS AND LOVED ONES

This argument holds that irremediable suffering is grounds for legalising assisted dying.

Even with more or better palliative care, there are some people whose suffering cannot be alleviated. Certain types of pain can be difficult to alleviate or cannot be controlled completely. Advances in medical practice have helped to prolong life, but for some this means an extended period of suffering. A recurring related argument is that it is cruel and contradictory to allow euthanasia of pets and other animals that are suffering, but not people.

Existing methods of pain relief, such as continuous palliative sedation, may not be viable for those who want to remain lucid or do not want to prolong their suffering.

Also, the existential suffering experienced by people at the end of their lives cannot be palliated in all cases.

People whose suffering cannot be relieved should have access to assisted dying.

Assisted dying enables people to ensure they are surrounded by loved ones at the time of death and have the chance to say goodbye to friends and family. Further, the death is more peaceful than it would otherwise be. This has benefits for the patient and the family, who can use the certainty around time of death to say final goodbyes, and are spared the trauma of suffering and seeing their loved one suffer.

## **PREVENTING SUICIDES AND ASSOCIATED SUFFERING**

With assisted dying unavailable, people with illness or injury that are suffering, or anticipate suffering, suicide alone, often in violent or disturbing ways. Having the option of assisted dying would allow these people to either end their lives in a more humane manner or let their illness run its course. It would provide them comfort in the knowledge that they could end their life with assistance if they decided to.

## **ASSISTED DYING OCCURS NOW BUT IS UNREGULATED**

Assisted dying occurs already in Australia, despite being unlawful. It occurs within and outside of medical settings. The instances that occur within medicine are nearly impossible to police. As these practices are not regulated, there are no safeguards, and the ongoing unlawful practice of assisted dying brings the law into disrepute.

## **ASSISTED DYING IS NO DIFFERENT TO REFUSING TREATMENT AND RECEIVING CONTINUOUS PALLIATIVE SEDATION**

There is no moral distinction between refusing or stopping treatment, combined with continuous palliative sedation, and providing assisted dying. This is particularly so when continuous palliative sedation is combined with removing nutrition and hydration. There is no logical basis for prohibiting assisted dying but permitting the refusal of treatment where the consequences are the same. If the distinction between continuous palliative sedation and assisted dying is 'intention', or intended and foreseen consequences, then it is too slight to identify precisely and routinely.

## **BENEFIT TO THE DOCTOR-PATIENT RELATIONSHIP**

Doctor-patient relationships will be enhanced by the openness and honesty that legalising assisted dying will foster. Discussing whether to stop treatment or administer continuous palliative sedation has not diminished trust between doctors and patients, by the same token an openness around assisted dying will not be harmful, but will be beneficial. Current restrictions on this discussion undermines the doctor-patient relationship, the ability to discuss all end of life options can only enhance it.

## **THE CURRENT LAW TREATS PEOPLE DIFFERENTLY**

The prohibition on assisted dying affects people differently and is therefore discriminatory. Some individuals have the physical ability to commit suicide, while the physical circumstances of others may prevent them from doing so. Further, some individuals may have the financial resources to travel overseas to jurisdictions such as Switzerland where assisted dying is lawful, while others may not.

## **THE OPTION OF ASSISTED DYING IS PALLIATIVE**

The option of assisted dying is in itself palliative and gives many peace of mind. Fear of death often stems from the fear of dying badly. Knowing that assisted dying can be accessed eases concern about the prospect of a 'bad death'.

## **ASSISTED DYING IS UNCOMMON**

Assisted dying will not cause the consequences its opponents fear because it is not something a large percentage of people desire for themselves.

## **OPPONENTS WOULD BE UNAFFECTED BY CHANGE**

Opponents to assisted dying will not be affected by a change in law, but those who want assisted dying are adversely affected by the current situation.

## GOD

God would want us to take a compassionate approach to those who are suffering. Providing assisted dying is a compassionate option.

## PUBLIC OPINION FAVOURS LEGALISING ASSISTED DYING

There is a long-standing history of strong public support for assisted dying in certain circumstances. In Australia, opinion polls have consistently shown public support for assisted dying.

Polling body	Date	Question	Yes	No
Newspoll	2007	Thinking now about voluntary euthanasia, if a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering asks for a lethal dose, should a doctor be allowed to provide a lethal dose, or not?	80%	14%
Newspoll	2009	Thinking now about voluntary euthanasia, if a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering asks for a lethal dose, should a doctor be allowed to provide a lethal dose, or not?	85%	10%
Australia Institute	2010	This question is about voluntary euthanasia. If someone with a terminal illness who is experiencing unrelievable suffering asks to die, should a doctor be allowed to assist them to die?	75%	13%
Newspoll	2012	Thinking now about voluntary euthanasia, if a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering asks for a lethal dose, should a doctor be allowed to provide a lethal dose?	82.5%	12.7%
Australia Institute	2012	This question is about voluntary euthanasia. If someone with a terminal illness who is experiencing unrelievable suffering asks to die, should a doctor be allowed to assist them to die?	71%	12%
ABC Vote Compass	2013	Terminally ill patients should be able to legally end their own lives with medical assistance.	75.1%	15.5%
Essential Media Communications	2014	When a person has a disease that cannot be cured and is living in severe pain, do you think should or should not be allowed by law to assist the patient to commit suicide if the patient requests it? <b>NB:</b> this poll used the term "commit suicide", which is thought to be the reason for the lower than usual 'Yes' response	66%	14%
Ipsos Mori	2015	What do you think of doctor-assisted dying? Do you think it should be legal or not for a doctor to assist a patient aged 18 or over in ending their life, if that is the patient's wish, provided that the patient is terminally ill (where it is believed that they have 6 months or less to live), of sound mind, and expresses a clear desire to end their life?	73%	15%
Essential Media Communications	2015	When a person has a disease that cannot be cured and is living in severe pain, do you think should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?	72%	12%
ABC Vote Compass	2016	Terminally ill patients should be able to legally end their own lives with medical assistance.	75%	16%

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**Dying with Dignity**   
New South Wales

GEOFF'S STORY (not his real name) as told to Liz Jacka, DWD NSW.

26 March 2017

This is a story about Geoff's father's death. His name was Pete and he had lived in [REDACTED] for his whole life.

Pete had been very influenced by seeing the way his father, Jimmy, died. Jimmy was a road-maker in [REDACTED] who worked a lot with tar. He developed some kind of skin cancer. He was taken to [REDACTED] hospital for radiation treatment. When Pete visited Jimmy in hospital, Jimmy was 'skin and bones' and said to Pete 'bring the gun'. He didn't, of course, because Jimmy was in hospital, but at that moment Pete vowed he would never go like that and would never go to a nursing home.

In 2002 Geoff's mother developed both dementia and Parkinson's and was nursed by Pete for 11 years. She died in 2013. Six months before her death, Pete had gone for a routine blood test for his diabetes and was diagnosed with myeloma. He was given a 'radio-active drug' (whose name I didn't catch). He responded well to the drug for a time but then the disease came back very severely. He felt very tired and very unwell. He also suffered a stroke and a heart attack over the next year or so and was extremely frail (at this time he was 80). He was living by himself in his house in [REDACTED] but had a daughter in [REDACTED] who saw him every day; however she worked full time.

His frailty became such that he needed a carer so his nephew, Aden, moved in. He began to have blood transfusions in [REDACTED] Hospital. Pete was still hopeful and still fighting and his [REDACTED]-based specialist was trying to get him on to new wonder drug. Only his GP was 'honest enough' to tell him the truth about his prognosis.

In March 2015 Pete went into [REDACTED] Hospital for a blood transfusion. Geoff visited him and they had a heart to heart. Pete cried and said he no longer wanted to be a burden to himself and others. On the Sunday he went home in a bad state. On the Monday morning Aden, his carer, had to go to [REDACTED] airport to pick up his father. Pete said to Aden, 'I'll be OK'. On Adam's return he found that Pete had killed himself. He was unable to use his gun as it was in a locked cupboard in the garage which was impossible for him to reach in his feeble state. What they worked out was that he had done was go to the kitchen and get a knife, then return to his bedroom, used the knife to break the window and had thrown himself over the broken glass on to the concrete below. He left a note thanking his medical team and saying 'it's time to go'.

The Coroner recorded the death as 'death due to head trauma due to fall', not as suicide, which Geoff is resentful of because it covers up the true situation. Geoff visited the Police Station after the Coroner's investigation was complete because he was aware the young constables who attended the death had been very upset by it. Geoff wanted to thank them. The police Sergeant who had also attended Pete's death said to Geoff 'that's the sixth one this month'. Geoff interpreted this to mean sixth suicide of elderly people with terminal diseases but he's not sure.