Invitation for Public Submissions
Inquiry into End of Life Choices in the ACT

On 30 November 2017, the ACT Legislative Assembly established a Select Committee to review and report on end of life choices in the ACT.

The Committee is required to conduct its inquiry and report to the Legislative Assembly on or before the last sitting day in 2018 (29 November 2018).

The Committee’s full terms of reference are to inquire into and report on:
1. current practices utilised in the medical community to assist a person to exercise their preference in managing the end of their life, including palliative care;
2. ACT community views on the desirability of voluntary assisted dying being legislated in the ACT;
3. risks to individuals and the community associated with voluntary assisted dying and whether and how these can be managed;
4. the applicability of voluntary assisted dying schemes operating in other jurisdictions to the ACT, particularly the Victorian scheme;
5. the impact of Federal legislation on the ACT determining its own policy on voluntary assisted dying and the process for achieving change; and
6. any other relevant matter.

The Committee is inviting all those interested in the inquiry to make a submission to the inquiry.

Lodgement of submissions is requested by c.o.b. Friday 23 March 2018. (Please note: Date extended from 23 February 2018)

The Committee prefers submissions to be type-written and submitted in electronic form, although handwritten submissions are also acceptable.

All submissions should include an email address, a postal address and a telephone contact number. Submissions are to be sent to: LACCommitteeEOLC@parliament.act.gov.au

The Secretary, Select Committee on End of Life Choices in the ACT, Legislative Assembly for the ACT, GPO Box 1020, CANBERRA ACT 2601.

If you would like to make a submission but will have trouble meeting this deadline, please contact the committee secretary.

Please feel free to pass this information to other people and organisations you feel may be interested in the inquiry.

For further information about the inquiry please contact the Committee Secretary, Andrew Snedden on (02) 6205 0199 or at andrew.snedden@parliament.act.gov.au.
SUBMISSION TO THE ACT LEGISLATIVE ASSEMBLY SELECT COMMITTEE ON END OF LIFE CHOICES

To: The Secretary, Select Committee on End of Life Choices in the ACT, Legislative Assembly for the ACT, GPO Box 1020, CANBERRA ACT 2601.

and: The Select Committee

Ms Bec Cody MLA (Chair)
Mrs Vicki Dunne MLA (Deputy Chair)
Ms Tara Cheyne MLA
Ms Elizabeth Kikkert MLA
Ms Caroline Le Couteur MLA

FROM: DYING WITH DIGNITY ACT INC.
E: [redacted]
Postal address: [redacted] Waramanga ACT 2611
T: [redacted]

TERMS OF REFERENCE TO BE ADDRESSED
1. Current practices utilised in the medical community to assist a person to exercise their preference in managing the end of their life, including palliative care;
2. ACT community views on the desirability of voluntary assisted dying being legislated in the ACT;
3. risks to individuals and the community associated with voluntary assisted dying and whether and how these can be managed;
4. the applicability of voluntary assisted dying schemes operating in other jurisdictions to the ACT, particularly the Victorian scheme;
5. the impact of Federal legislation on the ACT determining its own policy on voluntary assisted dying and the process for achieving change; and
6. any other relevant matter.
1. Current practices utilised in the medical community to assist a person to exercise their preference in managing the end of their life, including palliative care;

Current practices allow the medical community to;

Permit people who are dying to refuse treatment. This usually results in a long, slow death.

Permit people who have been given Power of Attorney to advise them about a dying person’s wishes.

However the existing practices utilised in the medical community also ensure that

Some people are ‘saved’ against their will.

Some people are forced to live by means of artificial respiration and other means without their agreement.

Some people are assisting their loved ones to die regardless of the law.

Some people are accessing illegal drugs to ensure a peaceful death.

Some people are not getting the assistance they need when they are dying.

Some people are being subjected to neglect in nursing homes.

If they wish to undertake the lawful act of ending their own lives people can only hang, gas or shoot themselves.
2. ACT community views on the desirability of voluntary assisted dying being legislated in the ACT

Dying with Dignity ACT Inc. is making a submission to this enquiry because it has the following aims which it wishes to see achieved in the ACT.

AIMS

Preamble

We assert that our bodies belong to us as individuals and that we have the right to determine the circumstances of our dying & death as we have in the rest of our lives. We expect our community to support our wishes and provide the facilities required to enable us to have the death of our choice.

Aims

1. To work with the ACT community to create the legal environment in which all adult ACT & region residents can die with dignity at a time and place of their choice with the degree of assistance that they determine is appropriate.
2. To promote the concept of an elective death as an alternative to concepts of suicide or voluntary euthanasia and to encourage support for elective death on Medicare.
3. To promote the idea that those who want to shorten their lives should be able to have a peaceful death.
4. To encourage the use of medication that would provide people with a peaceful, pain free, quick death.
5. To educate the community about the role and work of medical professionals & carers for the dying and to work for their legal protection if they assist a person who has made a reasoned choice to die.
6. To encourage & educate people about dying and death so that they will be fully informed about what will happen to them when they die and to encourage participation in courses which allow people to celebrate their lives, to grieve the loss of their lives and to think positively about death.
7. To support and encourage other like-minded organizations in Australia and internationally to create a legal environment in which people can die with dignity at a time and place of their choice with the degree of assistance that they determine is appropriate.
8. To promote the addition of a right in Human Rights law to a peaceful, pain free, quick death at the time and place of the individual’s choice with the degree of assistance that s/he determines is appropriate.

DWDACT Inc. was formed in 2012 for the purpose of achieving the aims stated above. It sees law reform as highly desirable for many reasons including the unlawfulness of and the contradictions in the current law and the human rights breaches that ACT citizens suffer as a result of the current law.

DWDACT Inc. has had a long history as an organization from the 1980s when it was a branch of the Voluntary Euthanasia Society of NSW. This shows a longstanding commitment of some ACT citizens to reform of the law to allow assistance to die.
3. Risks to individuals and the community associated with voluntary assisted dying and whether and how these can be managed;

The risks promoted by those who oppose voluntary assisted dying include
1. The spiritual risk that comes from the belief that giving assistance to die is the same as committing murder,
2. That a change to the law to allow assisted dying will lead to involuntary assistance,
3. That a change to the law to allow assisted dying will force doctors to assist whether they wish to or not, and
4. That a change to the law to allow assisted dying will not be supported by access to effective medication to bring about death.

DWDACT Inc. recommends that the ACT government adopts the following proposal because it answers all the risks raised above except for the spiritual one. However the Australian Constitution states that the Federal Parliament may not make laws for imposing religious observances and it also states that State laws must be consistent with Federal law. DWDACT Inc. addresses this last matter in point 5.

AN ELECTIVE DEATH

An Elective Death is based on the following principles

- It is the responsibility of government to ensure that everyone dies with dignity.
- A good health system should be able to guarantee a good death.
- An elective death will be a peaceful, pain-free and quick death.
- A civilized society respects the rights of its citizens to die at the time of their choice.
- To elect death is a legitimate goal that some people have for themselves. Like birth, death is a matter of individual choice and in the same way it should be supported by the state.
- Elective death is defined as a voluntary decision to shorten one’s own life.

An Elective Death Unit

1. An Elective Death unit would be well-publicized in or linked to a local hospital. The most effective medication would be purchased by the hospital and managed safely like all other medications in hospitals. It would be made available to the EDU staff as required.

2. The Elective Death Unit would have a) a 24 hour a day service with the resources to make professional personal, financial, and relationship counselling available to clients as well as immediate access to police, the coroner, organ donation and funeral services; b) an education facility designed for all members of the community and targeted for specific age groups and their particular stage of life needs to educate and inform people about death; to assist people to let go of life, to understand what death is and to prepare themselves for death; c) rooms with the facilities to assist those wanting an elective death to die comfortably in the presence of people they select; d)
provision of the facilities to enable a peaceful, pain free and quick death to be undertaken in most cases independently without the help of other people.

3. The Elective Death Unit would provide any adult ACT citizen with an elective death following a) provision of a reason for the wish for death, b) offers of help through counselling or other assistance as needed, c) a cooling off period negotiated with the person wanting to die. The decision to die would be respected as would the decision to live.

4. On diagnosis of a terminal illness or a protracted chronic disease that brought unbearable suffering, those people diagnosed may request a referral from their doctors to the Elective Death unit for an elective death at the time of their choice. Accessing the counselling services of the Elective Death Unit would be a matter for them.

5. The Elective Death unit would be required to maintain records of the reasons for people requesting an elective death and report regularly to the Assembly on their findings.

6. The ACT Government would co-ordinate public and private health systems to link into the Elective Death unit so that they can refer clients to it.

<table>
<thead>
<tr>
<th>Death by Disease</th>
<th>An Elective Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide</td>
<td>Elective Death</td>
</tr>
<tr>
<td>People die by hanging, gassing, drowning shooting, jumping etc</td>
<td>People receive counselling and if they still want death they are provided with a peaceful death.</td>
</tr>
<tr>
<td>Doctors who assist death are criminals.</td>
<td>Doctors refer patients to the elective death unit.</td>
</tr>
<tr>
<td>People die without assistance in a variety of places as a result of their diseases.</td>
<td>People take a referral from their doctors to the elective death unit to die there. Alternatively elective death unit staff would go where they were required to go to assist a death.</td>
</tr>
<tr>
<td>Medical staff are required by law to make people as comfortable as they can but have to watch while people die.</td>
<td>Staff are trained to assist people to die. They would not have to have a medical background. The skills needed for this role do not require high level medical training. Training in counselling and in administration of drugs are all that is required.</td>
</tr>
</tbody>
</table>
4. The applicability of voluntary assisted dying schemes operating in other jurisdictions to the ACT, particularly the Victorian scheme

Laws to permit assisted dying have been made in:
- Switzerland
- Oregon (USA)
- The Netherlands
- Belgium
- Luxembourg
- Washington (USA)
- Columbia/District of Washington (USA)
- California (USA)
- Colorado (USA)
- Montana (USA)
- New Mexico (USA)
- Columbia (South America)
- Canada
- Victoria (Australia)

The least complicated and longest existing law allowing assisted dying was passed in Switzerland.

In an open letter posted on the internet Dignitas Director Ludwig Minelli explains how the law came about.

The Federal Council, which is the Swiss Government, drafted a federal Criminal Code during the last years of the 19th Century. Only in 1918 was this presented to the Swiss Parliament, which comprises two Chambers, the National Council and the States Council. Article 115 appeared in the draft Criminal Code in the same wording it has today but was numbered as Article 102. In Explanatory Notes that accompanied the draft legislation the Government told Parliament that suicide in modern criminal law is no longer a crime and that no section of society wanted a return to the old ideas in law. Here is the Explanatory Note (in German) as it appeared in the Official Journal (Bundesblatt) 1918, vol. V, page 32:

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Translation:
“Suicide is not a crime in modern criminal law and there is no suggestion from the people we should return to previous law. Furthermore, the counseling and aiding of a person to suicide can be an act of compassion. Hence, prosecution will ensue only if the counseling and aiding of suicide proceeds from selfish motives, such as when a perpetrator seeks to gain an inheritance or terminate his giving of care.”

Following 20 years of intermittent debate, the Swiss Parliament in 1938 approved the Federal Criminal Code in amended form. There was, however, no amendment to Article 102, now 115. The Federal Criminal Code came into force on 1 January 1942. The long delay between approval and enactment was due to a call for referendum by 50,000 citizens. When a referendum was finally held a majority voted for adoption of the Federal Criminal Code.

There is no mention of any opposition to Article 102 in the record of parliamentary debate.

There is a Record of Discussions of the Committee of Experts who prepared the draft Federal Criminal Code in the late 19th century. In that document there is no expressed intention to help the old or sick with assisted suicide. It was the German-speaking section of the EXIT organisation that discovered Article 115 in the early 1980s and saw the opportunity to legally assist suicides by respecting the condition stipulated in the Article. (This is an application of a common principle in law: *argumentum e contrario*, argument from the contrary.)

The rest of his letter is attached as Appendix 1

In Switzerland assisted dying is carried out by private organizations. People who wish to die approach these organizations which assess their requests on a case by case basis. Those who are not dying but feel that death is their only option are helped to find options to remain alive until their situation becomes clearly one where death is the best option for them. People who elect to die are given the medication which has been prescribed for them by a doctor and they take it themselves or they are enabled to take it themselves with a mechanical aid in the facilities of the organization selected or their own places of living with the assistance of trained volunteers.

Most other jurisdictions have specific requirements relating to the disease or level of suffering a person is enduring. Usually the only basis on which it is acceptable for a person to apply for an assisted death is a disease that will bring about death. They rely on the medical profession to carry out assisted dying. There are usually age requirements for the applicants. In most places except for Belgium the applicant for an assisted death must be over 18. There is often a body set up to monitor and oversee that doctors carry out what is specified in the law.
The Victorian law conforms to the criteria described in the previous paragraph. It is 135 pages long as opposed to the Swiss paragraph and the 8 pages of the Belgian law.

The Elective death model that DWDACT Inc. proposes combines features from various jurisdictions. According to current ACT law anyone who shortens their lives, no matter for what reason, is ‘committing suicide’. We have reframed that expression because in our view it is not possible to ‘commit suicide’ which means self-murder when the law clearly states that ending one’s own life is not a crime. Murder is a crime. Self-murder is not a crime, therefore it should be called something else and we propose that it should be called an ‘elective death’. This is a feature of the DWDACT Inc. model for an assisted death that is unlike anything in any other model. It responds to the human right in ACT Human Rights law not to have our reputations unlawfully attacked.

DWDACT Inc. is in favour of the models in Oregon and Switzerland which give a high level of autonomy to the people making their decisions about their deaths and we see an elective death unit with staff trained in assisting death as desirable in a small location like the ACT with three hospitals because it would provide safe storage of lethal medication and a discrete known location for people to die. The Swiss model provides the locations but is still dependent on doctor prescriptions for the medications which the doctor may refuse to give. The Oregon model allows doctors to prescribe and patients may go to die anywhere they choose. They may not die within the six months specified and they have the lethal medication in their homes. This dependence on doctors and the lack of a secure environment for the medication seems undesirable to us.

DWDACT Inc. sees the current criminalization of the person who provides an assisted death as a serious form of hypocrisy and breach of human rights. The current law gives the illusion that dying of a disease or hanging, gassing or drowning ourselves are acts we choose of own free will but in fact the way we die - whether by disease or other method - has been imposed by the law that prevents assistance to die.

When Kevin Andrews argued for the 1997 Euthanasia Laws Act he stated that it would be a form of suicide prevention as if either everyone would suddenly want to end their lives if they did not have a law that denied access to assistance or that it would bring the suicide rate down. Neither of these things is true.

Most people want to live because, like most animals, we have an inbuilt natural desire to live. And the ‘suicide’ rate has not gone down despite millions of dollars being thrown at so-called ‘suicide prevention’ and people being more informed about the matter. The truth is some people in every society that has kept records since ancient societies formed, have ended their lives before they died of disease. The current law does not solve this problem. All it does is force people who want to die into not talking about their wish and finding a mechanism that helps them do what they need to do. Or alternatively and most usually, they accept their ‘lot’ and die of the disease that will inevitably catch up with them as the law requires.
Most assisted dying models focus on the issue of decriminalization of the assister. The assister is usually found in the role of the doctor because most models limit an assisted death to a person who is terminally ill or suffering from an ongoing chronic unbearable disease. This is a clumsy mechanism because in any jurisdiction there are many doctors who therefore because of their numbers have to be closely supervised in order to prevent abuses. Some doctors are also unwilling to be involved and this is a complication that has to be built into the law. These factors have been worked over ad nauseam in the Victorian law. Compare the simplicity of the Swiss and Belgian laws.

DWDACT Inc. proposes that elective death units closely linked to our hospitals would be more administratively effective. In the ACT not many people die each year. Most people die of their diseases and around thirty elect to die by hanging etc. Small units like these could be highly effective at providing the autonomy people have experienced throughout the rest of their lives at the end of their lives. A referral from their doctor for those who are either terminally ill or suffering from a debilitating disease would provide access to a quick, peaceful death. Like any referral it can be used or not. The dying or suffering person makes the choice.

If a doctor refused to give a referral patients would be able to take their medical records to the Elective Death Unit to verify their health conditions. In this circumstance a doctor from the hospital to which the unit is attached could provide the referral after checking the medical records.

For those who are not dying but who wish to undertake the lawful act of an elective death counselling would be available and an opportunity to talk about the problem that has led them to conclude that death is the only answer. The elective death model assumes acceptance of death rather than fear of death. The elective death model offers a way to regulate what is a completely unregulated aspect of modern life at the moment. Because the law takes a punitive attitude to the desire to die, people who undertake this lawful act have to do it secretly and usually violently. There is no regulation in this approach. In fact it is shockingly unregulated. It should not be acceptable in a modern society for relatives to have to find their loved ones hanging dead in their garage or dead in a car or hanging in a park or mutilated having thrown themselves from a high building. Regulation of an elective death can only occur when people have a place to go to die where there will be no judgement.

The elective death model proposes the training of people specifically for the job of assisting people to die. It would be a new health specialization. This would avoid the problem of the lack of trust of doctors, role conflict for doctors and doctor refusal. People going to the Elective Death unit would know that the person who was there had the specific task of helping them to die. There would be no ambiguity or complexity in the role. The staff would be located in a small number of places and mechanisms could be set up to ensure professionally responsible behaviour. Staff would be able to go to nursing homes, homes etc as required. They would liaise between the applicant, services required, the hospital, family members and funeral services. Small units could be supervised by each hospital and reporting could be done though the current hospital system to the Assembly’s health system and to the Assembly.
The elective death model assumes the age of 18 as the requirement for an assisted death but it is likely that exceptions may need to be made for children suffering from unbearable diseases if the child shows an understanding of a wish for death.

Very few young people end their own lives but children who do wish to do so would be better for knowing that there was a place they could go specifically set up for the purpose of talking about their desire to die. Many children could be helped with fears that they see only death resolving by knowing there was some place to go that would make no judgements about them.
5. The impact of Federal legislation on the ACT determining its own policy on voluntary assisted dying and the process for achieving change

Dying with Dignity ACT Inc. believes that the 1997 Euthanasia Laws Act is unlawful and is seeking legal advice to make a challenge to it in the High Court. We believe that the Euthanasia Laws Act is in breach of Section 116 of the Australian Constitution which states

The Commonwealth shall not make any law for imposing any religious observance.

We believe that the Euthanasia Laws Act is based on religious observance and attach the Declaration on Euthanasia from the Vatican's website as evidence. We also believe that the Liberal politicians who argued for this law did so because it was religious and found it shockingly unacceptable to give the assistance to die proposed by the Northern Territory’s Rights of the Terminally Ill Act because it failed to maintain the religious observances regarding death.

We note the following remarks made in the second reading in support of the Euthanasia Laws Act in Federal Parliament as evidence of our views;

Peter Costello, the then Deputy Prime Minister and treasurer spoke in favour of it saying

My view is that the dignity of life is such an important principle to be valued above other human rights that it should never be surrendered easily and, if at all possible, never surrendered. It is a religious belief; a moral belief, if you like. You either take that view or you do not, in my opinion. People who do not take it I do not think will ever be persuaded. But it is fundamental, I think, to the beliefs that have guided our civilisation and our society from the days of the Ten Commandments. It is the Judaeo-Christian ethic, `Thou shalt not kill.' My belief is that, as a result, human life is something important and the dignity of life is to be prized highly.

Another Coalition MP Mr Baldwin stated

The Holy Bible teaches us that our bodies are not our own to do whatever we like with; that God created us in his image and that we are the stewards of those bodies and, as stewards, we will be given an opportunity to give account of that stewardship. Our bodies are the temples of God and therefore sacred to Him and it is not our right to destroy that which is not ours to own. In doing so, we break the fifth commandment, `Thou shall not kill.'

Dying with Dignity ACT Inc. believes that the ACT and Northern Territory governments should join it in making a legal challenge in the High court if the advice we receive supports our view. If successful this challenge would free the ACT to make its own arrangements and modifications to existing law.
6. Any other relevant matter

Law should be based on fact not religious belief or prejudice. It should be helpful to people in living their lives from birth to death.

The facts of death relate to the facts of life. We come into this world as a result of our parents’ sexual activity and for no other reason.

Human life has evolved to be no longer than 120 years. The Australian median age of death is around 82 years. Some life is very brief, a butterfly’s life for example, and some very long; for example there are trees that live for thousands of years.

We are all made of 7 billion atoms. These atoms have come from the particles that were present at the Big Bang. So the atoms we are made of have already existed for 13.8 billion years. The length of life of an atom is just under 35 billion years so all the atoms we are made of have over 20 billion years of life to live. When we die we break down to our atomic state and our atoms are eventually recycled by the universe into other things made of atoms. See Appendix 4

Basing law on religious ideas is unhelpful to the natural passage we must make from life to death and on to our next existence. There is no evidence for God. We belong to ourselves, not God. The State should stop passing laws on the basis that there is a God and that it has the right to act in God’s interests to stop us from making our own choices in relation to our deaths.

Section 16 of the Crimes Act Suicide etc – not an offence

The rule of law that it is an offence to commit, or to attempt to commit, suicide is abolished.

This law was a very good first step in returning ownership of our bodies to us but it did not go far enough. Once this law was passed the act of ending one’s own life and choosing to move out of this life should have been renamed. Once this law was passed the act of ending one’s own life became a health and human rights problem for governments to solve not by continuing to label it self-murder or by forcing people to die by cruel means by denying them assistance to die. In the ACT the effect of the following laws;

Suicide – aiding etc

1) A person who aids or abets the suicide or attempted suicide of another person is guilty of an offence punishable, on conviction, by imprisonment for 10 years.

Section 18 Prevention of Suicide

It is lawful for a person to use the force that is reasonable to prevent the suicide of another person or any act that the person believes on reasonable grounds would, if committed, result in the suicide of another person.
is to contradict the following ACT Human Rights laws.

Section 8 Recognition before the law
Everyone has the right to enjoy his or her human rights without distinction or discrimination of any kind.

- Article 26 of the International Covenant on Civil and Political Rights states that ‘All persons are equal before the law and are entitled without discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.’

Human Right: Everyone has the right not to have his reputation unlawfully attacked.

Human Right: Protection from torture and cruel, inhuman or degrading treatment 1 b) No-one may be treated or punished in a cruel, inhuman or degrading way.

Human Right: Right to Liberty and Security of person; 1) Everyone has the right to liberty and security of person.

Human Right: Every person has the right to life and has the right not to be arbitrarily deprived of life.

People in the ACT who undertake the lawful act of an elective death no matter what the reason i.e. whether they are dying or have some difficulty in their lives, will have their reputations attacked by being called a ‘suicide’. The effect of Section 17 which denies them assistance to die is to subject them to treatment that is cruel, inhuman and degrading by forcing them to hang, gas or drown themselves. The right to liberty and security of person is not available to people who want to undertake the lawful act of ending their own lives when the only means accessible to them are violent or illegal.

No-one asks to be born. Life is imposed on us by our parents. While it is right to expect that we should not be arbitrarily deprived of life, given that it is not a crime to end one’s life, neither should we be expected to arbitrarily die of disease as the current law forces us to do. The Canadian Supreme court found that the Canadian Crimes Act breached the right to life of Canadians who were dying and who were more than capable of deciding that they wanted to die.

The assumption that we belong to God is used to justify death by disease because, suffering, especially suffering during the last moments of life, has a special place in God’s saving plan; it is in fact a sharing in Christ's passion and a union with the redeeming sacrifice which He offered in obedience to the Father’s will.

Polls consistently inform us that even religious Australians do not see it as necessary for us to die suffering. We know it is not necessary to suffer at death and that there is
medication to ensure that we do not suffer. Assistance to die can be as minimal as handing someone a small glass of a lethal medication after ensuring that person is sure that death is what they want. The situation in Switzerland and Belgium shows that it does not have to be a highly complicated legal rigmarole.

DWDACT Inc. believes that ACT law should be based on reason, fact and its own environment. While it is useful to know what decisions other jurisdictions have made the ACT Legislative Assembly will have to make its own decisions for itself.

Aside from the administrative and practical advantages outlined above another advantage of the Elective Death model is that it can be implemented in stages.

Stage 1. Establish 1 Elective Death unit at one ACT hospital for dying people and those suffering unbearably to be referred to.
Stage 2. Establish the counselling part of the Elective Death unit.
Stage 3. Establish the Education Centre of the Elective Death unit.

Stage 4. Repeat these stages in other hospitals as needed over time.

Stage 5. Once established as a feature of the ACT Health system, the Units could be sold to private organizations to run if that was thought to be desirable.
APPENDICES
Dear Mr. Todd,

Thank you for your e-mail.

Until 31 December 1941, every one of the 24 Swiss Cantons had its own Criminal Code. (There was, however, a federal Criminal Code for the Military.)

The Federal Council, which is the Swiss Government, drafted a federal Criminal Code during the last years of the 19th Century. Only in 1918 was this presented to the Swiss Parliament, which comprises two Chambers, the National Council and the States Council. Article 115 appeared in the draft Criminal Code in the same wording it has today but was numbered as Article 102. In Explanatory Notes that accompanied the draft legislation the Government told Parliament that suicide in modern criminal law is no longer a crime and that no section of society wanted a return to the old ideas in law. Here is the Explanatory Note (in German) as it appeared in the Official Journal (Bundesblatt) 1918, vol. V, page 32:

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You ask whether Article 115 has increased the rate of suicide in Switzerland.

In Australia with its population of 21 million I understand there are some 2'200 suicides each year. In Switzerland with its population of 7 million there are some 1'450 suicides each year. But how many attempts lie behind these actual suicide figures? I am told that researchers in Australia give a best estimate of 30 attempts for each actual suicide, but concede the true figure could lie anywhere between 20 and 50. The Swiss Government told its parliament on 9 January 2002 that, based on U.S. research, there are possibly 50 attempts for each actual suicide in Switzerland. That would suggest up to 72'000 suicide attempts each year with some 70'000 failures. There are heavy consequences, not only for the persons involved but also for the economy. There are estimates that attempted suicide in Switzerland has an annual cost of 1.2 to 2.4 billion Swiss Francs, most of this arising from failed attempts.

Why is it that most countries have been unable to reduce their annual rates of suicide?

In my opinion the answer lies in the choice of a starting position for corrective measures. If we start from a position that all suicide is detrimental to society and not a single incidence should be accepted, then we create a taboo. And once a taboo surrounds suicide, no one with suicidal tendencies can freely share their thoughts and feelings on the subject with friends, relatives or medical practitioners. Were they to do so they risk embarrassment and worse, incarceration in a psychiatric institution. So the person enters a downward spiral with little chance of recovery.

We can improve this by moving the starting point for our corrective measures. We can accept that in some instances suicide offers the best course of action and that rational humans can make use of that valuable opportunity. That is, suicide can provide the desired release from an untreatable, unrelievable illness. However, we must acknowledge that a person with suicidal tendencies may not be aware of the real situation. So, in line with the precautions we take when going on a long journey (i.e. consulting a travel agency for advice and saying goodbye to our relatives and friends) we should set two conditions on the person contemplating suicide: obtain diagnosis and prognosis from the medical profession and farewell friends and relatives.

These conditions provide opportunity for others to consider the basic problem of the suicidal person and solve that problem by means other than suicide should that be possible. Should there be no better solution and the person persistently seeks suicide, we should be able to give assistance to ensure a peaceful, painless death.

When, as a consequence of such an approach, all suicides become assisted suicides, the total number of suicides would be much lower, and there would be no failed suicides with their heavy consequences. We have already seen the achievement of a similar outcome with abortion. Since legalization, abortions have been carried out under expert medical supervision which has eliminated deaths and serious complications. In some countries we have actually seen a decrease in rate of abortion.

When I started as a journalist in 1956 I noticed that Switzerland’s rate of suicide matched its road deaths, some 1'600 per year. In 2005 this figure had fallen to about 1'350, and it included some 350 assisted suicides. The figures speak for themselves: the availability of assistance actually decreases the rate of suicide.
Has the availability of assistance led to large numbers of people choosing suicide in preference to natural death? Well, Georg Bosshard with others from the Institute of Legal Medicine of the University of Zurich published a study of 748 suicides that were assisted by EXIT in Switzerland over a period of eleven years from 1990 to 2000. He compared the total number of deaths in Switzerland to the total number of assisted suicides by EXIT over those eleven years. Of 100'000 persons who died in these eleven years from cardiac or respiratory disease, only 67 (.07%) chose assisted suicide. Of 100'000 persons who died from Multiple Sclerosis, only 45 (4.5%) chose assisted suicide. These figures (and similar figures released annually in the state of Oregon USA) show that when assisted suicide is legalized, only a small minority will actually use it. (Figures from Oregon USA show that not only is it a small minority but one composed mostly of persons suffering from cancer, motor neurone disease, AIDS and Multiple Sclerosis. These are the particular diseases that too frequently bring on unbearable suffering.)

I have more evidence from Switzerland. In 2001, the City Council of Zurich ruled that organizations such as EXIT and DIGNITAS could attend the homes of old or sick people run by the City of Zurich to give assisted suicide when requested. Only recently I asked the Chief physician of the City of Zurich, Dr. Albert Wettstein, how many people live in these institutions and how many cases of assisted suicide have occurred in the last few years. He informed me that about 3'000 people live in these homes and there are no more than three assisted suicides each year. (I am aware that the actual figure might be slightly higher because an EXIT official, Werner Kriesi, told me that in 2004, three persons - all members of EXIT - came from these institutions to the EXIT house to die because they did not want to go through the official bureaucracy in the home.) Whether the actual figure is three or six per year, it amounts to a very small percentage.

Our experience at DIGNITAS is that 70 percent of our members who approach us for assisted suicide never call again after we have told them that a Swiss physician is ready to write a prescription for them.

So what is the conclusion? A country wishing to reduce its rates of both attempted and actual suicide will achieve this by legalizing assisted suicide. This should be combined with information campaigns so that people learn that it is not a simple matter to commit suicide successfully. Many of the methods thought to work do not. Persons contemplating suicide should be strongly advised to seek assistance. In doing so they would discuss their problems and possibly find better solutions than death. But should death be the best solution, each would be assisted to die peacefully and painlessly.

To achieve this requires human intelligence freed of religious and medical dogma. There may lie the rub.

Yours sincerely

DIGNITAS

Ludwig A. Minelli
INTRODUCTION

The rights and values pertaining to the human person occupy an important place among the questions discussed today. In this regard, the Second Vatican Ecumenical Council solemnly reaffirmed the lofty dignity of the human person, and in a special way his or her right to life. The Council therefore condemned crimes against life "such as any type of murder, genocide, abortion, euthanasia, or willful suicide" (Pastoral Constitution Gaudium et Spes, no. 27).

More recently, the Sacred Congregation for the Doctrine of the Faith has reminded all the faithful of Catholic teaching on procured abortion.[1] The Congregation now considers it opportune to set forth the Church's teaching on euthanasia. It is indeed true that, in this sphere of teaching, the recent Popes have explained the principles, and these retain their full force[2]; but the progress of medical science in recent years has brought to the fore new aspects of the question of euthanasia, and these aspects call for further elucidation on the ethical level. In modern society, in which even the fundamental values of human life are often called into question, cultural change exercises an influence upon the way of looking at suffering and death; moreover, medicine has increased its capacity to cure and to prolong life in particular circumstances, which sometime give rise to moral problems. Thus people living in this situation experience no little anxiety about the meaning of advanced old age and death. They also begin to wonder whether they have the right to obtain for themselves or their fellowmen an "easy death," which would shorten suffering and which seems to them more in harmony with human dignity. A number of Episcopal Conferences have raised questions on this subject with the Sacred Congregation for the Doctrine of the Faith. The Congregation, having sought the opinion of experts on the various aspects of euthanasia, now wishes to respond to the Bishops' questions with the present Declaration, in order to help them to give correct teaching to the faithful entrusted to their care, and to offer them elements for reflection that they can present to the civil authorities with regard to this very serious matter.

The considerations set forth in the present document concern in the first place all those who place their faith and hope in Christ, who, through His life, death and resurrection, has given a new meaning to existence and especially to the death of the Christian, as St. Paul says: "If we live, we live to the Lord, and if we die, we die to the Lord" (Rom. 14:8; cf. Phil. 1:20). As for those who profess other religions, many will agree with us that faith in God the Creator, Provider and Lord of life - if they share this belief - confers a lofty dignity upon every human person and guarantees respect for him or her. It is hoped that this Declaration will meet with the approval of many people of good will, who, philosophical or ideological differences notwithstanding, have nevertheless a lively awareness of the rights of the human person. These rights have often, in fact, been proclaimed in recent years through declarations issued by International Congresses[3]; and since it is a question here of fundamental rights inherent in every human person, it is obviously wrong to have recourse to arguments from political pluralism or religious freedom in order to deny the universal value of those rights.

I. THE VALUE OF HUMAN LIFE
Human life is the basis of all goods, and is the necessary source and condition of every human activity and of all society. Most people regard life as something sacred and hold that no one may dispose of it at will, but believers see in life something greater, namely, a gift of God's love, which they are called upon to preserve and make fruitful. And it is this latter consideration that gives rise to the following consequences:

1. No one can make an attempt on the life of an innocent person without opposing God's love for that person, without violating a fundamental right, and therefore without committing a crime of the utmost gravity.[4]

2. Everyone has the duty to lead his or her life in accordance with God's plan. That life is entrusted to the individual as a good that must bear fruit already here on earth, but that finds its full perfection only in eternal life.

3. Intentionally causing one's own death, or suicide, is therefore equally as wrong as murder; such an action on the part of a person is to be considered as a rejection of God's sovereignty and loving plan. Furthermore, suicide is also often a refusal of love for self, the denial of a natural instinct to live, a flight from the duties of justice and charity owed to one's neighbor, to various communities or to the whole of society - although, as is generally recognized, at times there are psychological factors present that can diminish responsibility or even completely remove it. However, one must clearly distinguish suicide from that sacrifice of one's life whereby for a higher cause, such as God's glory, the salvation of souls or the service of one's brethren, a person offers his or her own life or puts it in danger (cf. Jn. 15:14).

II. EUTHANASIA

In order that the question of euthanasia can be properly dealt with, it is first necessary to define the words used. Etymologically speaking, in ancient times Euthanasia meant an easy death without severe suffering. Today one no longer thinks of this original meaning of the word, but rather of some intervention of medicine whereby the suffering of sickness or of the final agony are reduced, sometimes also with the danger of suppressing life prematurely. Ultimately, the word Euthanasia is used in a more particular sense to mean "mercy killing," for the purpose of putting an end to extreme suffering, or having abnormal babies, the mentally ill or the incurably sick from the prolongation, perhaps for many years of a miserable life, which could impose too heavy a burden on their families or on society. It is, therefore, necessary to state clearly in what sense the word is used in the present document. By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used. It is necessary to state firmly once more that nothing and no one can in any way permit the killing of an innocent human being, whether a fetus or an embryo, an infant or an adult, an old person, or one suffering from an incurable disease, or a person who is dying. Furthermore, no one is permitted to ask for this act of killing, either for himself or herself or for another person entrusted to his or her care, nor can he or she consent to it, either explicitly or implicitly. nor can any authority legitimately recommend or permit such an action. For it is a question of the violation of the divine law, an offense against the dignity of the human person, a crime against life, and an attack on humanity. It may happen that, by reason of prolonged and barely tolerable pain, for deeply personal or other reasons, people may be led to believe that they can legitimately ask for death or obtain it for others. Although in these
cases the guilt of the individual may be reduced or completely absent, nevertheless the error of judgment into which the conscience falls, perhaps in good faith, does not change the nature of this act of killing, which will always be in itself something to be rejected. The pleas of gravely ill people who sometimes ask for death are not to be understood as implying a true desire for euthanasia; in fact, it is almost always a case of an anguished plea for help and love. What a sick person needs, besides medical care, is love, the human and supernatural warmth with which the sick person can and ought to be surrounded by all those close to him or her, parents and children, doctors and nurses.

III. THE MEANING OF SUFFERING FOR CHRISTIANS AND THE USE OF PAINKILLERS

Death does not always come in dramatic circumstances after barely tolerable sufferings. Nor do we have to think only of extreme cases. Numerous testimonies which confirm one another lead one to the conclusion that nature itself has made provision to render more bearable at the moment of death separations that would be terribly painful to a person in full health. Hence it is that a prolonged illness, advanced old age, or a state of loneliness or neglect can bring about psychological conditions that facilitate the acceptance of death. Nevertheless the fact remains that death, often preceded or accompanied by severe and prolonged suffering, is something which naturally causes people anguish. Physical suffering is certainly an unavoidable element of the human condition; on the biological level, it constitutes a warning of which no one denies the usefulness; but, since it affects the human psychological makeup, it often exceeds its own biological usefulness and so can become so severe as to cause the desire to remove it at any cost. According to Christian teaching, however, suffering, especially suffering during the last moments of life, has a special place in God's saving plan; it is in fact a sharing in Christ's passion and a union with the redeeming sacrifice which He offered in obedience to the Father's will. Therefore, one must not be surprised if some Christians prefer to moderate their use of painkillers, in order to accept voluntarily at least a part of their sufferings and thus associate themselves in a conscious way with the sufferings of Christ crucified (cf. Mt. 27:34). Nevertheless it would be imprudent to impose a heroic way of acting as a general rule. On the contrary, human and Christian prudence suggest for the majority of sick people the use of medicines capable of alleviating or suppressing pain, even though these may cause as a secondary effect semi-consciousness and reduced lucidity. As for those who are not in a state to express themselves, one can reasonably presume that they wish to take these painkillers, and have them administered according to the doctor's advice. But the intensive use of painkillers is not without difficulties, because the phenomenon of habituation generally makes it necessary to increase their dosage in order to maintain their efficacy. At this point it is fitting to recall a declaration by Pius XII, which retains its full force; in answer to a group of doctors who had put the question: "Is the suppression of pain and consciousness by the use of narcotics ... permitted by religion and morality to the doctor and the patient (even at the approach of death and if one foresees that the use of narcotics will shorten life)?" the Pope said: "If no other means exist, and if, in the given circumstances, this does not prevent the carrying out of other religious and moral duties: Yes."[5] In this case, of course, death is in no way intended or sought, even if the risk of it is reasonably taken; the intention is simply to relieve pain effectively, using for this purpose painkillers available to medicine. However, painkillers that cause unconsciousness need special consideration. For a person not only has to be able to satisfy his or her moral duties and family obligations; he or she also has to prepare himself or herself with full
consciousness for meeting Christ. Thus Pius XII warns: "It is not right to deprive the dying person of consciousness without a serious reason."[6]

IV. DUE PROPORTION IN THE USE OF REMEDIES

Today it is very important to protect, at the moment of death, both the dignity of the human person and the Christian concept of life, against a technological attitude that threatens to become an abuse. Thus some people speak of a "right to die," which is an expression that does not mean the right to procure death either by one's own hand or by means of someone else, as one pleases, but rather the right to die peacefully with human and Christian dignity. From this point of view, the use of therapeutic means can sometimes pose problems. In numerous cases, the complexity of the situation can be such as to cause doubts about the way ethical principles should be applied. In the final analysis, it pertains to the conscience either of the sick person, or of those qualified to speak in the sick person's name, or of the doctors, to decide, in the light of moral obligations and of the various aspects of the case. Everyone has the duty to care for his or her own health or to seek such care from others. Those whose task it is to care for the sick must do so conscientiously and administer the remedies that seem necessary or useful. However, is it necessary in all circumstances to have recourse to all possible remedies? In the past, moralists replied that one is never obliged to use "extraordinary" means. This reply, which as a principle still holds good, is perhaps less clear today, by reason of the imprecision of the term and the rapid progress made in the treatment of sickness. Thus some people prefer to speak of "proportionate" and "disproportionate" means. In any case, it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources. In order to facilitate the application of these general principles, the following clarifications can be added: - If there are no other sufficient remedies, it is permitted, with the patient's consent, to have recourse to the means provided by the most advanced medical techniques, even if these means are still at the experimental stage and are not without a certain risk. By accepting them, the patient can even show generosity in the service of humanity. - It is also permitted, with the patient's consent, to interrupt these means, where the results fall short of expectations. But for such a decision to be made, account will have to be taken of the reasonable wishes of the patient and the patient's family, as also of the advice of the doctors who are specially competent in the matter. The latter may in particular judge that the investment in instruments and personnel is disproportionate to the results foreseen; they may also judge that the techniques applied impose on the patient strain or suffering out of proportion with the benefits which he or she may gain from such techniques. - It is also permissible to make do with the normal means that medicine can offer. Therefore one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community. - When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. In such circumstances the doctor has no reason to reproach himself with failing to help the person in danger.
CONCLUSION

The norms contained in the present Declaration are inspired by a profound desire to service people in accordance with the plan of the Creator. Life is a gift of God, and on the other hand death is unavoidable: it is necessary, therefore, that we, without in any way hastening the hour of death, should be able to accept it with full responsibility and dignity. It is true that death marks the end of our earthly existence, but at the same time it opens the door to immortal life. Therefore, all must prepare themselves for this event in the light of human values, and Christians even more so in the light of faith. As for those who work in the medical profession, they ought to neglect no means of making all their skill available to the sick and dying; but they should also remember how much more necessary it is to provide them with the comfort of boundless kindness and heartfelt charity. Such service to people is also service to Christ the Lord, who said: "As you did it to one of the least of these my brethren, you did it to me" (Mt. 25:40).

At the audience granted prefect, His Holiness Pope John Paul II approved this declaration, adopted at the ordinary meeting of the Sacred Congregation for the Doctrine of the Faith, and ordered its publication.


Franjo Cardinal Seper
Prefect

Jerome Hamer, O.P.
Secretary

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REFERENCES
[4] We leave aside completely the problems of the death penalty and of war, which involve
specific considerations that do not concern the present subject.

Appendix 3

KEYNOTE ADDRESS
ASIA PACIFIC CORONERS SOCIETY CONFERENCE
ADELAIDE 1ST NOV 2017

MARSHALL PERRON

VOLUNTARY EUTHANASIA AND THE CORONIAL PROCESS

(A message from the dead)

I was very pleased when I received the invitation to address you today from Mark Johns. This conference gives me the opportunity to press further - points I made to coroners in a letter 3 years ago - and is not to be missed.

In brief, I advocated that coroners should identify a cohort of self-inflicted death by the elderly and the terminally and hopelessly ill that is premature, lonely and usually violent. I wanted coroners to report that such deaths would likely be delayed, and trauma reduced, if the person could legally access assistance to die at a later point in time.

This is one audience that knows better than any other the awful facts about how desperate people die, and the effect on those close to them. (actually, I wonder if anybody who has not had the experience really knows ….. effect... on those intimately close to an unexpected suicide.)

To another gathering I would get attention by referring to a man who killed himself with shots to his head and chest with a nail gun that Victorian coroner John Ollie spoke about recently.

You are familiar with such occurrences. All in a day’s work I guess. (I presume not without an effect)

Mark Johns responded to my advocacy by agreeing that the current situation was a sad reflection on society, but that what I asked would not only require resources way beyond those available to coroners, but also that… Quote “as members of the judiciary, coroners should not involve themselves in a political debate as hotly contested as that one.”
He said politicians, who I claimed were blissfully ignorant of the extent of the problem, were quite capable of ascertaining the facts if they cared to inquire. That is surely true, however our MP’s seem so preoccupied with bagging each other that the plight of constituents who may not be alive at the next election, is not of great interest.

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I emphasize here that my following remarks refer to people who are terminally ill, not any other group of troubled citizens who might consider ending their life.

Today I want to argue that there is a fundamental flaw in the charter coroners operate under. That is, the presumption that all unnatural death should be prevented.

It is wrong to believe that every instance of suicide is a tragic event that governments should do everything in their power to stop.

The progression of lifespan in the advanced world, with death now the result of degenerative disease, often preceded by a long period of debilitation, is changing the way we view our inevitable demise. (a reduction in religious belief and the desire for autonomy and control no doubt contributing factors.)

The overwhelming majority of Australians want the option of a peaceful death for themselves if their end of life circumstances warrant.

They realise the adage ‘growing old is better than the alternative’ - is only true up to a point.

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When I announced I would introduce a Bill to legalize voluntary euthanasia 25 years ago in the Northern Territory, the reaction was completely unexpected. I and my colleagues were overwhelmed with mail and calls from all over Australia, from people with a terrible story about the death of someone close to them.

It was like I had scratched society and it started to bleed.
People desperately wanted to tell someone of a dramatic experience they had kept bottled up (inside) for years. At last they felt there was someone who might understand what they had been through.

I spoke to people who had killed their parent in response to desperate pleas to end the suffering. Ordinary people with no experience or knowledge of how to extinguish life, pushed to the very edge of emotional endurance. Acting in sheer desperation. The experience seared into their memory forever.

I received moving letters that put a lump in my throat and were hard to finish.

The outpouring convinced me to pursue the agenda. The objective of relieving futile suffering was a just one.

I regularly hear the view that legalizing voluntary euthanasia is a very complex, hard thing to do.

I just do not see it that way, never have.

Everyone knows how to kill themselves, people are doing it all the time.

You know that better than anyone – the problem is how the group I’m talking about do it. Violently - and alone.

We simply need to define the group we believe have good reason to want to hasten their death, and allow them the option of doing so serenely. Competent terminally ill adults fill the first criteria, and pentobarbital the second.

Slide 1. “My bill was based on this principle.. “*If there are terminally ill patients who wish to end their suffering by accelerating inevitable death, and there are sympathetic doctors who are willing to help them die with dignity, then the law should not forbid.*”.

I describe it as getting the keys to the medicine cabinet...

It would be a law that did not require anybody to do anything. Anyone who disagreed could live their life as if the option did not exist.
A couple of years ago I attended the big funeral of a 92-year-old man I admired greatly. Those attending heard stories of a long life of hard work, tears, love, laughter and giving within a large family and his community.

What the congregation was not told was that Henry died miserably and alone. A classic case of rational suicide to end unbearable suffering from the ravages of multiple operations, and a decaying body.

To protect his family Henry devised a plan and assembled the equipment needed without help from anyone, and died when the family were out of the house.

Questioned by police, the family denies knowledge or involvement and goes into lockdown to try and prevent the truth becoming known. (It’s hard to hide from the neighbours with police cars out front for a few hours.)

It’s a pretty standard story - Similar and worse happens every day across the country.


I’m incensed that the only knowledge of Henry’s plight the community will ever see, is the usual platitudes in the death notices saying, ‘died peacefully’, and a figure published by the ABS in about 2 years.

Instead of ‘Death by suicide’ being 3112 it will be 3113.

In reality, the world is oblivious to the way Henry died.

If there was a political reaction – it would be to throw some more money at suicide prevention programs, an action completely contrary to what is needed to help people like Henry. We don’t need money, we need legislative change.

I believe it is a tragedy that Henry, like so many others, was denied the opportunity to die peacefully in the arms of his wife of 70 years and generations of his descendants.
While we deplore any waste of healthy life, I find people in their 80 & 90’s, even 100 years old, hanging themselves to be particularly horrifying. Not because of the life foregone - but because a society that patronizes the elderly leaves some of them no choice but to die violently and alone.

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I guess Coroners are too busy to keep up with goings-on in other states, so I want to talk about the Dying with Dignity movement’s new pin up celebrity.

Victorian Coroner John Ollie. His evidence before the inquiry into end of life choices by the Parliamentary Standing Committee on Legal and Social Issues - October 2015, had a considerable impact on the committee.

Close observers believe it was the turning point in the committee making the ground-breaking recommendation that the government sponsor a Bill to legalize assisted dying. (which they have done)

I suspect Coroner Ollie was unusually personal when giving evidence by saying. Quote “My motivation initially some time ago to refer several cases that I was investigating to our coroners prevention unit, was really - would I want a member of my family to die in the circumstances of loneliness, fear and the horror of some of these cases we are privy to — would I want that? The answer was a resounding no. People who have invariably lived a long, loving life surrounded by family, die in circumstances of fear and isolation.” End quote

This is the classic ‘me’ test we should all take when deciding if assisted dying should be legalized.

Mr Ollie described 5 shocking cases to the committee. I will not go into detail as most in this room would be familiar with the horrific ways ‘intentional self-harm’ occur(s).

He defined the cohort as ‘Irreversible decline’ - terminal disease; death was foreseeable; incurable chronic disease but death not imminent; permanent physical incapacity and pain. The cohort did not include mental ill health.
He said they were people who unlikely would meet the criteria of palliation….and that it is information Coroners alone are privy to.

I quote further from his evidence…”When I first referred this cluster of cases, they are obviously — and for anyone would be — so distressing. There was no panel; there was no inquiry afoot, or even mooted, and that was my great concern — that there has not been information that we have, that the community do not have, and should have - to be aware, and to address this important issue.”

…There is a cry for help. It may be muted, it may be veiled, but it is there nonetheless, and they all know it — including doctors. They know that this person is screaming for help, but no-one is going to answer this call; not in this society. So they have got to die alone.

….to my knowledge the people we are talking about in this small cohort have made an absolute clear decision. They are determined. The only assistance that could be offered is to meet their wishes, not to prolong their life” end Quote.

Politicians may not listen to us lay citizens who have bleated about such suicides for decades but they certainly listened to coroner Ollie....... 

If ‘reassuring the public’ is a role of the coroner, Mr Ollie’s evidence did just the opposite. His powerful evidence alarmed the committee and hopefully will sway MP’s when they vote on the Bill. I applaud him for what he did.

He may have broken a legislative logjam where 30 Bills in the last 20 years have piled up in the face of ignorance, misinformation and innuendo.

The West Australian parliament has recently established an inquiry into end of life options with the same terms of reference as Victoria. I hope and expect the WA Coroner’s Office will give evidence of similar deaths contained in their files.

The Victorian experience demonstrates that coroners have an important contribution to make as our society grapples with the legislative changes
required to authorize voluntary assisted death - the new term to sit alongside one you are very familiar with - *Intentional Self Harm*.

Progressing this concept requires revisiting the doctrine ‘That death is to be prevented in all circumstances.’

We have reached a stage in our biological and social evolution where an individual can reasonably conclude that, for them, the stage has been reached where living longer is undesirable - even unacceptable.

When thinking about suicide - I’m always drawn to the awful example of people leaping to their death from the burning World Trade Centre. In some respects their plight was similar to the terminally ill. Both know they are going to die and are seeking the least painful way for it to happen. From that point on their situation differs significantly. One has only minutes or seconds to make a decision between two options. The terminally ill however have the advantage of a much longer period to consider what to do, the ability to discuss the subject with others and multiple choices regarding method.

What they do not have however is access to the most effective way to die quickly, or to assistance from others. In both cases the action has to be taken while the individual retains the physical and mental capacity.

In my research to talk to you today I came upon this description of the coroner’s role. *Quote*“The coroner speaks for the dead to protect the living.” *End quote.*

(This drove home to me that the dead really can communicate - I was a skeptic when once asked to join a seance.)

That may be an appropriate description for most of your important work however there is another message from the dead that we have not been hearing. - Until Coroner Ollie shocked his audience.
The cohort of Intentional Self Harm, terminally or incurably ill, or the new description ‘irreversible decline’ send the message....

Slide 2  “Death is not the worst thing that can happen to you – relentless unbearable suffering is.”

We have ignored the message from the extraordinary lengths competent people are prepared to go to end their suffering - to escape the life they live, or face, as their health deteriorates and the capacity for experiencing anything even remotely enjoyable slips away.

How determined would one have to be to die from injuries to the head and chest from a nail gun.

Adding to the agony of ending one’s life secretly is the knowledge of what it will do to loved ones who are often taken by surprise. And the certainty they will face investigation by the police and possibly the coroner.

We accept that life-saving medical treatment can be refused to allow nature to take its course – but we will not condone anyone deliberately shortening their own life.

While it may not be unlawful to take your own life, we do what we can to make it hard. Rope, knives, trains and tall buildings are available as is starvation but to get hold of the means to a quick tranquil death requires becoming a criminal.

And, of course, don’t ask anyone for assistance.

Elderly people fret about their arthritic hands failing them while opening the valve on the gas bottle, or travelling to Mexico when they are very ill and dealing with dodgy characters in the street to buy Nembutal, and hoping like hell it is the real thing. Then having to become a criminal by smuggling it home without appearing nervous in the customs hall. Reports of the Australian Federal Police searching homes to confiscate your treasured bottle of insurance is a worry. Many fear suddenly losing control by being hospitalised or sent to a nursing home or even palliative care - places they associate with agonising prolonged deaths.
This group, who we are often told are the vulnerable in society are certainly vulnerable to being denied their wishes if they express a wish to die.

Our attitude – stop them! Remove the means, tell them we love them, pump them full of drugs so they can bear the pain... and if that doesn’t work - sedation and death by dehydration will.

One very successful example of removing the means occurred when (in 2011) a NZ coroner reported on two helium deaths and recommended that the gas be contaminated with oxygen to prevent people dying this way.

This action was brilliantly successful... one gas company announced they would... and now word thru-out the DWD community is helium is out. Whether the company did or did not add oxygen is irrelevant. No-one is prepared to take the risk.

I doubt it has reduced VE deaths. It has probably just meant a swing to nitrogen....

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The driving force behind the voluntary euthanasia movement is, in fact, not the gruesome suicides that come across a coroner’s desk. The ones like my friend Henry, who the public know little about because it is deemed they should not be told.

What Coroners see is the tip of the iceberg,- below the surface, mingled among the non-reportable deaths are the ‘hard’ ones. Those who, in the opinion of witnesses, die dreadfully. And I don’t just mean die dreadfully in the opinion of family members who might be considered biased, but nurses and doctors and palliative care practitioners as well.

The number of hard deaths is unknown and depends on the definition used but some studies put the figure between 8 and 23% of all deaths in Australia. That’s 12 to 36 thousand. I believe knowledge of such dying experiences is what is convincing the public there should be a more acceptable way to die.
The majority of hard deaths are not reported or required to be under the law - so I acknowledge I cannot ask coroners to speak for the dead you are not obliged to consult.

... and the living can speak for themselves.

However there is an elephant in the room with bad deaths and there may be a case for Coroners, perhaps thru the NCIS to recommend a study of the incidence and administration of terminal sedation in Australia. Currently the extent of the practice is unknown, no guidelines exist to regulate it - there is no scrutiny. Palliative care practitioners are reluctant to talk about it.

Death is unnatural but certainly expected.

However one looks at it, terminal sedation is slow euthanasia, the sole purpose of withholding food and fluid from a sedated patient is so they will die. Otherwise they could be fed intravenously until death was caused by the underlying illness.

The charade that has been played out for decades is the pretence that hastening death to end intractable pain and suffering is not intended. The difference between the act being murder or one protected by the doctrine of double effect rests solely in the mind of the administrator. Where it remains opaque, near impossible to prove - making investigation futile.

Who would know if the doctrine of double effect is shielding abuse or cover up? It is likely doctors sign dozens of certificates every day where death was the result of sedation and withholding hydration.

Confirming what we already know, Dr Brendan Nelson, when president of the Australian Medical Association in 1995 supported doctor assisted death. He said, quote "Technically it would be illegal but somebody would have to report it and register a complaint. "Now if you do your job properly there’s no way the family’s going to complain." He said the police would not lay charges if the doctor could prove he had the family’s backing and had sought the proper expert advice.*

When Prime Minister, Tony Abbott, agreed with his radio interviewer that pain relief was often given with the intention of speeding death. He said,
quote "Quite possibly you're right, Neil, and when was the last time any doctor or anyone was prosecuted for something like that? I think the situation that we've got at the moment is a perfectly acceptable one." **

There we have it, no lesser authority than the Prime Minister and the head of the AMA saying doctors intentionally kill terminally ill patients now, that it is breaking the law and that is perfectly acceptable.

The ‘rule of law’ is being trashed every day and no one seems to be concerned. (we once sent a former Federal court judge to jail over lying about a parking fine yet we let doctors get away with murder)

If part of a coroner’s role is to consider the administration of justice, there seems to be some attention needed here.

It is perverse to us advocates that one’s death can be deliberately hastened with the administration of drugs over several days - yet a request for drugs to die within minutes is prohibited.

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The position of Coroner I see began in England over 700 years ago. (1281 - impressive) I read quote; “A person who found a body from a death thought sudden or unnatural was required to raise the ‘Hue and Cry’ and notify the Coroner.” End quote

So – on behalf of Henry and a thousand others – and in the interest of a compassionate society - I HEREBY RAISE A HUE AND CRY.

There is unnecessary misery, grief and trauma out there in the suburbs caused by outdated laws that compel rational adults to die violently and alone.

You may respond by saying Coroners do examine such deaths as resources permit and report their findings accordingly, that it is not your role to set public policy or change the law, and I agree.

That is a job for politicians. Therein lies a problem.
The political agenda is jam packed. Our legislators face severe pressure juggling their party, electoral, government and private lives in this age of almost frighteningly rapid change and a 24 hour news cycle.

One old cliché, “The squeaky wheel gets the oil” is still true.

I find it perplexing that our federal government can be shocked into conducting a royal commission into youth detention within 12 hours of seeing a picture of a boy in a spit hood, when the fact that 600 elderly Australians died with plastic bags over their heads in the last 20 years hardly rates a mention.

We voluntary euthanasia advocates simply have not made enough fuss to be heard by politicians. The ‘Hue & Cry’ has to be louder. Much louder.

While our legislators do have access to your work, (if they ask) all the grim findings, recommendations and statistics, they are either unaware, unmoved or afraid to tackle the issues involved in devising a legal assisted dying regime.

Notwithstanding public support of between 75 to 85%, none of the 30 private members bills introduced in state parliaments over the past 20 years have been successful.

I’m here to push the gravity of the case for change. That’s where you come in.

We advocates have for two decades now, badgered MPs with individual experiences of bad deaths both personal and as relayed to us by others. We express our determination to do whatever it takes to avoid our own inevitable death being a repeat of what we have witnessed.

We claim law reform would extend lives and reduce trauma but our message has not been heeded by legislators. Mostly - letters are ignored, newsletters are binned and appointments fobbed off to a staffer. Nothing we have done has elevated the issue to priority status. We are yet to see if the message will get through in Victoria.
Even the extraordinary level of public support for law reform is discounted on the basis that come the next election, the deciding major issues will be those established beforehand by the major parties.

The bad deaths, the resulting trauma, some of it lasting for years, are out of sight and out of mind.

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Sometimes I wonder if some of our elected representatives do not want to hear the truth of what is contained in the files of coroners.

I’m reminded of the scene in the film ‘A Few Good Men’ when Jack Nicholson playing the tough General answers the prosecuting lawyer Tom Cruise with “The truth! You can’t handle the truth.” He was referring to what special force soldiers do out there in the dark to protect the community.

Meanwhile the search for the holy grail, the ‘peaceful pill’ that governments cannot control continues.

While our politicians scramble to catch up with technological change, from driverless cars to personal data collection to artificial intelligence, we are on the verge of the first head transplant and genetically designed babies. I predict an app will become available to end life painlessly. When it does, the angst about law reform to permit voluntary assisted dying will likely disappear. We won’t need anyone’s permission. (the app might cost a bit though - no repeat customers)

Back in 1998, American professor of Philosophy Margaret Battin wrote of a societal change in attitude toward death - she predicted it could lead to …..

Slide 3. ‘Dying becoming not something that happens to you, but something you do.’

This change she said followed the formal recognition of a right to refuse treatment, the removal of life support, the ability to appoint surrogate decision makers and advance care directives.
It seems, if as the polls show, most Australians want the option of an assisted death if things get bad – that we are inching toward dying being, for some of us, ‘something you do’.

Part of our cultural evolution perhaps.

A couple of thousand years ago, Epicurus is said to have coined the phrase.....

Slide 4 ‘The circumstances of my death are too important an event to be left to chance.’ (Considering life back then was short and brutal I think Epicurus would feel even stronger today if he thought he might die in a nappy, having been spoon fed for 2 years.) I confess this sentiment appeals to me.

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Mark Johns told me that it is not for Coroners to enter a debate as hotly contested as this one... Ok, I won’t ask you to...however - I am asking you to build on the action of Coroner Ollie when he exposed the dark and tragic drama playing out (every day) across the country...conveniently masked in media reports by the term ‘no suspicious circumstances.’

Every MP in every government needs to have the information you alone are privy to. Even if the Bill in Victoria does pass, there is a long way to go before all our citizens have the option of a peaceful death.

I acknowledge that Coroners can only comment on cases before them however your authority to make a recommendation to a minister, a statutory authority or another entity on issues relating to public health and safety and the administration of justice is virtually unfettered.

While a coroner’s report on the death of a single individual can lead to legislative action, the chances of it occurring are naturally multiplied if similar cases in other jurisdictions are added. Therein lies the value of the NCIS.

The NCIS has an important role producing fact sheets in relation to issues of community and public importance. I am advised the topics for NCIS factsheets are decided are based on a number of factors, including data quality, feasibility, and the extent to which the fact sheet would provide a novel contribution to public debate.
It is hard to imagine a subject of more interest to the public you serve than that which concerns 85% of the adult population of this country i.e. access to the means to die a tranquil death in the face of a dreadful one.

I repeat, the cases in your files are just the tip of the iceberg. There are many more in the same desperate situation who want but are denied a peaceful quick death as they are trapped in the confines of a hospital, palliative care unit or nursing home where the timing of their demise is out of their control.

The current wave of baby boomers are an educated, assertive lot, less in awe of doctors than ever before with a diminishing belief in spirituality. Having witnessed the deaths of their parents and grandparents and knowing that even the best palliative care cannot relieve all suffering.... many consider their own death too significant an event to be left to chance. They want an option to avoid the cruel lottery that natural death can be and the human cost of the unexpected discovery of a mutilated body by family.

It does not have to be that way. A compassionate society would permit the option of a gentle, peaceful death at a time of choice in the company of loved ones.

John Ollie has opened the subject by describing a cohort of self-inflicted deaths that are understandable, reasonable and without coercion.

They are however brutal in every way. Acceptable alternatives are available but they are currently illegal.

I conclude by posing the question Mr Ollie asked himself - to you. “Would you want a member of your family to die in circumstances of loneliness, fear and horror?

If the answer is no – then please, in the public interest, find an opportunity to say so - and reveal the information only you are privy to.

END

* Sunday Territorian May 21 1995
** Neil Mitchell talk-back 3AW Sept 2013
Appendix 4.

WHAT HAPPENS WHEN WE DIE?

“All things are made of atoms”
They are everywhere and they constitute everything.
They are fantastically durable.
Every atom you possess has almost certainly passed through several stars and been part of millions of organisms on its way to becoming you. We are so atomically numerous and so vigorously recycled at death that a significant number of our atoms - up to a billion for each of us, it has been suggested-probably once belonged to Shakespeare …..and any other historical figure you care to name …… it takes the atoms some decades to become thoroughly redistributed.
So we are all reincarnations – though short lived ones. When we die, our atoms will disassemble and move off to finds new uses elsewhere – as part of a leaf or other human being or a drop of dew. Atoms themselves, however go on practically forever. Nobody actually knows how long an atom can survive but ….. it is probably about 1035 years


Virtually everything we see and touch and feel is made up of collections of particles that have been involved in interactions with other particles right back through time, to the Big Bang in which the universe as we know it came into being. The atoms in my body are made of particles that once jostled in close proximity in the cosmic fireball with particles that are now part of a distant star, and particles that form the body of some living creature on some distant, undiscovered planet. Indeed, the particles that make up my body once jostled in close proximity and interacted with the particles that now make up your body.