



LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON END OF LIFE CHOICES IN THE ACT

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

Submission Cover Sheet

End of Life Choices in the ACT

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Select Committee on End of Life Choices in the ACT
Legislative Assembly for the ACT
GPO Box 1020
Canberra ACT 2601

Attention: Ms Bec Cody MLA (Chair)

Dear Ms Cody,

HOPE is pleased to present a submission to the Select Committee on End of Life Choices in the ACT.

HOPE: Preventing Euthanasia and Assisted Suicide is a coalition of groups and individuals who oppose the legalisation of euthanasia and assisted suicide. We are opposed to euthanasia and assisted suicide from a human rights and justice perspective, based upon the firm belief that euthanasia and assisted suicide pose significant risks for vulnerable people of all ages.

The Committee may wish to visit the HOPE: No Euthanasia website which contains many more resources about the issue of euthanasia and assisted suicide:
<http://www.no euthanasia.org.au/>

We trust this submission will assist the Committee with its deliberations to ensure that the most vulnerable in our community will have the protection that is rightfully theirs from a government that prioritises care for its most vulnerable.

We would be pleased to speak with the Committee in relation to any aspect of this Submission.

Yours sincerely,

Ms Monica Doumit
Spokesperson



**Legislative Assembly for the Australian Capital Territory
Select Committee on End of Life Choices in the ACT**

We submit that it is not desirable to legalise assisted suicide in the ACT for the following reasons:

- 1. Euthanasia and/or assisted suicide is a public act that affects the whole of society, not just the individual involved, and represents an abrogation of the state's duty to protect its own citizens, especially the vulnerable.**

If euthanasia or assisted suicide are legalised in the ACT, this will open the door to a new oppression of those most vulnerable in our community.

One of the fundamental duties and responsibilities of government is to govern for all its citizens, and particularly those who are especially vulnerable, due to youth, old age, disability, infirmity or other reasons. This duty extends to protecting its citizens from injustice and oppression. All citizens have the right to expect that society will care for them from the "cradle to the grave"; that a government will provide adequate health care for every stage of life, not least of which when people find themselves at the end of their lives and are particularly in need of care. In a society where euthanasia and/or assisted suicide are not an option, there is no dilemma that presents itself for an elderly person who finds themselves ill or in need of long term care. There is a presumption that the state and/or family and friends will provide the care, no matter how long the illness takes. In a society which has legalised euthanasia and/or assisted suicide however, a dilemma immediately presents itself for the person – should they impose themselves on society and demand appropriate health care, or should they do the 'unselfish' thing and request euthanasia or assisted suicide? The latter option is cheaper and less of an imposition on everyone concerned. This consequence is inevitable as the cost of euthanasia or assisted suicide is significantly less than providing long term health care, with no known end date.

Proponents of euthanasia and assisted suicide argue that individuals should be free to do as they wish with their own bodies/lives, and that this decision affects no one else. On deeper reflection however, it is clear that such a decision absolutely affects more than just the individual involved. The act of euthanasia or assisted suicide is not, as proponents argue, a 'private' matter only for the person requesting assisted suicide. The act itself necessarily involves another person (either the doctor administering the lethal medication or providing the medication to the patient to take themselves), legislators and bureaucrats regulating the law, as well as family and friends of the person concerned.

As stated in the Minority Report of the Legal and Social Issues Committee *Inquiry into end of life choices - Final Report* in Victoria:

“...in both euthanasia and assisted suicide, the ethical dimensions are inherently more complex since third parties are necessarily involved. It is not enough to assert a belief in the individual’s right to autonomy. Any system of regulated euthanasia or assisted suicide must involve the active participation of members of the health profession and possibly also other regulatory arms of the state.”¹

Given that euthanasia and assisted suicide rely on a practitioner to either administer the lethal injection or provide the patient with the means to do it themselves, it is a nonsense to say that such a course of action only affects the individual concerned. To this end, research demonstrates the negative impact that euthanasia and assisted suicide can have on medical practitioners, including adverse stress, regret, and feeling ‘intimidated and coerced by the family’ of a patient to participate in the assisted suicide:²

“Physician participation in assisted suicide or euthanasia can have a profound harmful effect on the involved physicians. Doctors must take responsibility for causing the patient’s death. There is a huge burden on conscience, tangled emotions and a large psychological toll on the participating physicians.”³

This harmful effect on doctors is demonstrated with the drastic reduction in support of euthanasia from doctors following its legalisation. A survey of Canadian doctors showed that, prior to the legalisation of assisted suicide in that country, 78 percent of doctors expressed a willingness to be involved in assisted suicide. These numbers have now inverted, with 77 percent now claiming a conscientious objection to killing a patient.⁴

Indeed the Australian Medical Association has affirmed its position on euthanasia and assisted suicide to be that ‘doctors should not be involved in interventions that have as their primary intention the ending of a person’s life.’⁵

The impact is not only on doctors, but on others involved in medical care. In an essay providing front-line observations of 14 years of euthanasia in Belgium, oncologist, Professor

¹ Parliament of Victoria, Legislative Council, Legal and Social Issues Committee, *Inquiry into end of life choices*, Final Report, June 2016, Minority Report, beginning at p.343.

² Stevens, K.R. “Emotional and Psychological Effects of Physician-Assisted Suicide and Euthanasia On Participating Physicians,” *The Linacre Quarterly*, 2006, 73:3, 203-216.

³ Ibid at p.213.

⁴ Opatrny L., Bouthillier M. “Décoder l’objection de conscience dans le cas de l’aide médicale à mourir,” *Le Spécialiste*, 2017, 19:4, 36-40.

⁵ Australian Medical Association Position Statement “Euthanasia and Assisted Suicide” 2016, and can be found here:
<https://ama.com.au/system/tdf/documents/AMA%20Position%20Statement%20on%20Euthanasia%20and%20Physician%20Assisted%20Suicide%202016.pdf?file=1&type=node&id=45402>.

Benoit Beuselinck, notes that nurses and social workers in palliative care units have left the practice, as patients are increasingly referred to palliative care units for euthanasia.⁶

A decision to legalise euthanasia or assisted suicide therefore affects society as a whole and changes it fundamentally from one that has as its foundation the non-negotiable rule that 'you must not kill' to one that states that 'you may kill *some* people in *some* circumstances'. The unintended consequence then is that we move from a society where the old and vulnerable trust that they will be cared for in their old age and infirmity, to one where that same vulnerable group is no longer sure that society will care for them, and scared that they will be pressured to request euthanasia or assisted suicide in order to not be a burden on society and its finite resources.

2. The risk of elder abuse and coercion increases with the legalisation of assisted suicide

The House of Lords Select Committee on Medical Ethics found that in the Netherlands (where euthanasia has been legal since 2002), the experience of feeling vulnerable by its elderly citizens is very real:

"The full effect of the current situation was brought home to me following a meeting last week with a Dutch lady now living in the United Kingdom. She has a large number of elderly relatives in the Netherlands and members of the family are medical practitioners. She is informed and well educated about medical practice in the Netherlands. Last week she told me that her elderly relatives felt threatened by the current practice of euthanasia and worried that their lives would be ended without their consent. They felt betrayed by the Dutch Government for not protecting them."⁷

Palliative Care Victoria has also argued that the legalisation of euthanasia may lead to further pressure on the elderly and vulnerable in our society:

"There is a real danger that legalising euthanasia and/or assisted suicide will lead to a growing sense of a duty to die. Matters of life and death involve difficult and at times tragic choices. It is the responsibility of public policy and law to advance the public interest and to protect those who are most vulnerable."⁸

Once a jurisdiction allows euthanasia and/or assisted suicide as an option, it is impossible to safeguard against the elderly feeling that they have become a burden to society and feeling undue pressure to choose that option, whether for financial reasons or because family members or close friends are burdened by having to care for an elderly person who is frail or suffering a chronic illness. If there is a choice apart from the state or family or friends having to care for a sick person over the long haul, many people will feel pressured to take the option

⁶ Jones D.A., Gastmans C., MacKellar C. *(eds). "Euthanasia and Assisted Suicide: Lessons from Belgium." Cambridge University Press. 2017. United Kingdom.

⁷ House of Lords Hansard, UK Parliament, 6 May 1998, Column 709. Available here: <https://publications.parliament.uk/pa/ld199798/ldhansrd/vo980506/text/80506-12.htm>

⁸ Palliative Care Victoria, "Submission to the Legal and Social Issues Committee, Inquiry into End of Life Choices," July 2015 (Submission 236).

that will impose the least amount of burden on family and friends. They will feel that it is morally important that they do not burden others, especially because it is very difficult to predict how long an illness will take or what kind of suffering will ensue.

The state of Oregon in the United States legalised assisted suicide in 1997. The Oregon health department publishes statistics every year about the reasons why people request assisted suicide.

The data from Oregon shows that in 2016 nearly one out of two (48.87%) people who died after taking prescribed lethal medication cited concerns about being a “[b]urden on family, friends/caregivers” as a reason for the request.⁹ This is compared with the lower percentage (35.3%) of people who cited ‘inadequate pain or concern about it’ as the reason for requesting assisted suicide.¹⁰

If an elderly person is made to feel like a burden to their family this should be considered a warning sign for possible elder abuse. Family members experiencing ‘inheritance impatience’ may subtly or overtly influence an elderly, sick person to request assisted suicide. A recent parliamentary report on elder abuse in New South Wales also referenced the failure of professionals to identify undue influence and so unwittingly facilitated elder abuse.¹¹

Australia, like much of the western world, has an aging population. The Australian Law Reform Commission (‘ALRC’) has stated that “approximately 15% of the population was aged 65 or over in 2015, and this is expected to rise to 23% by 2055.”¹² Into the mix of issues that the ageing population presages is a most worrying trend: elder abuse. Elder abuse includes physical, financial and emotional abuse, often at the hand of a relative. The World Health Organisation (‘WHO’) has estimated that in high or middle-income countries the rate of elder abuse ranges between 2% and 14%.¹³ The Centre for Mental Health Research found that 6% of older Canberrans had experienced elder abuse.¹⁴ The difficulty with the data is the simple fact that elder abuse is known to be under reported precisely because it is often perpetrated by a relative.

⁹ Oregon Public Health Division, *Oregon Death With Dignity Act: Data Summary 2016*, Table 1. Characteristics and end-of-life care of 1,127 DWDA January 23, 2016 [sic 2017], by year, Oregon, 1998-2016, p.10
<http://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

¹⁰ Ibid.

¹¹ NSW Legislative Council, General Purpose Standing Committee No. 2, *Elder Abuse in New South Wales*, June 2016. <https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2387#tab-reports>

¹² Australian Law Reform Commission, *Elder Abuse – A National Legal Response: Final Report*, ALRC Report 131, May 2017, p. 18
https://www.alrc.gov.au/sites/default/files/pdfs/publications/elder_abuse_131_final_report_31_may_2017.pdf

¹³ Ibid, p.17.

¹⁴ Centre for Mental Health Research (2011), *A Baseline Survey of Canberra as an Age Friendly City*, Australian National University, Canberra, cited in ACT Government, *ACT Elder Abuse Prevention Program Policy*, June 2012, found here:
https://www.communityservices.act.gov.au/_data/assets/pdf_file/0004/317605/Elder_Abuse_Prevention_Program_Policy_2012_FINAL_2.pdf.

If most elder abuse is perpetrated at the hand of a relative, it must be recognised that the prospect of euthanasia and assisted suicide becoming law in the ACT could effectively be aiding and abetting elder abuse with extremely grave consequences. It is not hard to imagine that a relative who has been systematically abusing an elder emotionally and financially could see euthanasia as the final (and most profitable) card to play for personal gain. It is not hard to imagine someone who has been emotionally abused over time succumbing to the suggestion that they “do the right thing” once their frailty and ailments reach a certain point.

Undue influence is increasingly being seen as a relevant factor in the financial abuse of elders. Seniors Rights Victoria provides a useful summary of case law and best practice on undue influence in the financial abuse of elders.¹⁵

It is clear from this summary that undue influence can easily be missed and may be difficult to identify. A recent parliamentary report on Elder Abuse in New South Wales also referenced the failure of professionals to identify undue influence and so unwittingly facilitate elder abuse.¹⁶ Of course, the courts can apply the remedy of rescission if undue influence is established. However, in the case of assisted suicide, a failure to identify undue influence before writing a prescription for a lethal dose will be incapable of remedy once the lethal dose is ingested.

The Senior Rights Victoria report notes that “Capacity Australia” observed that financial abuse is often fuelled by ignorance and family conflict, as well as ‘inheritance impatience’... It further noted that undue influence by one family member over another is commonly facilitated by legal professions because of their failure to detect when an older person is struggling to manage their financial affairs, that is, when they lack financial capacity.”¹⁷ The report further noted that “Ms Lise Barry, Senior Lecturer at the Macquarie Law School has conducted research specifically on how lawyers assess the capacity of older people to instruct them. Lawyers sometimes have a very limited understanding of the interview skills required to determine an older person’s capacity to appoint a power of attorney or enduring guardian, and that they are doing so free of undue influence.”¹⁸

There is no evidence that medical practitioners are any better at identifying undue influence on a patient’s decision making.

In the United States, commentators have noted that:

“Proponents tout assisted suicide as providing ‘choice’ over the timing of one’s death. But choice under the Oregon and Washington Acts cannot be assured. For example, neither

¹⁵ <https://assetsforcare.seniorsrights.org.au/relationship-breaks-down/equity/undue-influence-unconscionable-dealing/>

¹⁶ NSW Legislative Council, General Purpose Standing Committee No.2, Elder Abuse in New South Wales, June 2016, <https://www.parliament.nsw.gov.au/committees/DBAssets/InquiryReport/ReportAcrobat/6063/Report%2044%20-%20Elder%20abuse%20in%20New%20South%20Wales.pdf>

¹⁷ Ibid p. 80, para 6.6.

¹⁸ Ibid, p. 107, paras 7.8 and 7.11.

act requires witnesses at the death. Without disinterested witnesses, the opportunity is created for an heir or someone else who will benefit from the patient's death, to administer the lethal dose to the patient without his consent. Even if he struggled, who would know? Assisted suicide is a concept contrary to public safety and a recipe for elder abuse."¹⁹

This feeling of vulnerability extends in a particular way to migrant communities, whose elderly members often have a very limited grasp of the English language. Evidence from Belgium, where euthanasia has been legal since 2002, is that some patients are now afraid to go to their doctor or hospital. There are others who carry cards with them, requesting that they not be euthanized.²⁰ Legalisation of euthanasia and assisted suicide may very well create mistrust between migrant communities and health professionals, if there is the possibility that euthanasia could be practised in situations where a migrant person feels particularly vulnerable due to their poor English language skills. This may result in elderly migrant people not presenting to their doctors for medical treatments as they age, creating a worrying gap in their health care options.

3. Overseas experience demonstrates that it is impossible to enact safeguards that will protect the vulnerable in our community

Overseas evidence clearly demonstrates that once a jurisdiction legalises euthanasia, 'safeguards' that are enacted are very quickly breached and expanded or removed:

"The 'logical slippery slope' – the expansion of the situations where euthanasia is allowed – has constantly enlarged. In the Netherlands, euthanasia is no longer restricted to competent adults with unbearable suffering able to provide informed consent. It's now available to children, new born babies with serious disabilities, and people with dementia and mental illness, such as depression, without physical illness. There are movements to legalise access to inflicted death for people 'over 70 and tired of life' or who feel they have a 'completed life'. Likewise, after just over a year of legalised euthanasia in Quebec, there are calls for it to be extended to euthanasia on demand, that is, that there should be no requirements for access by a competent person."²¹

The examples from overseas jurisdictions are too numerous to list exhaustively. The extensions that are now accepted in other jurisdictions where once the law was changed to deal with a small minority of cases of unacceptable pain and suffering include the following cases:

¹⁹ Margaret Dore, "Assisted Suicide Laws are a Recipe for Elder Abuse", New York Times, 10 April 2012 found here <https://www.nytimes.com/roomfordebate/2012/04/10/why-do-americans-balk-at-euthanasia-laws/assisted-suicide-laws-are-a-recipe-for-elder-abuse>

²⁰ Anscombe Bioethics Centre, 2014, "Euthanasia and Assisted Suicide: Lessons from Belgium," November 2014, p.3.

²¹ Margaret Somerville, "Legalising assisted dying would be a failure of collective human memory and imagination" The Guardian, 20 September 2017, accessed here: <https://www.theguardian.com/commentisfree/2017/sep/20/legalising-assisted-dying-would-be-a-failure-of-collective-human-memory-and-imagination>

- The Swiss Group 'Exit' has voted to extend assisted suicide to those who 'feel old'.²² Swiss law allows euthanasia providers to establish their own internal rules and the group added 'suicide due to old age' to its statutes by way of an annual general meeting, 'allowing people suffering from psychological or physical problems associated with old age the choice to end their life.'²³
- A 44-year-old transgender man was euthanized because he was devastated by the outcome of his sex change operation.²⁴
- Psychiatric patients in the Netherlands are euthanized.²⁵
- The Netherlands, Belgium and Luxemburg allow euthanasia and assisted suicide for dementia, alcohol and drug addiction, mental illness and disability, and Belgium and the Netherlands have reduced age restrictions to include minors.²⁶ In Belgium, data from 2015 shows that 15 percent of euthanasia cases (299 deaths) did not involve people who were terminally ill.²⁷

Evidence from overseas jurisdictions clearly demonstrates that safeguards are routinely breached in jurisdictions where euthanasia and assisted suicide have nevertheless been enacted with the promise of strict 'safeguards'.²⁸

4. Palliative care has advanced to the point where there are very rare cases that cannot be treated sufficiently through palliative care

One of the most prominent reasons given by advocates of euthanasia and assisted suicide is the wish to assist people who are suffering from 'intolerable pain', or serious or incurable conditions, and whose suffering is not able to be alleviated in a way that the patient considers tolerable.

However, in 2018, it is rare for patients to be in this situation. Evidence submitted to the 'Victorian Inquiry into end of life choices' demonstrates that palliative care has developed significantly in the past 20 years to the point where most, if not all, pain can be alleviated through appropriate palliative care.²⁹

²² <https://www.theguardian.com/society/2014/may/26/swiss-exit-assisted-suicide-elderly-not-terminally-ill>

²³ Ibid.

²⁴ Aviv, Rachel, "The Death Treatment", June 22 2015, *The New Yorker*, <https://www.newyorker.com/magazine/2015/06/22/the-death-treatment>.

²⁵ <http://www.dutchnews.nl/news/archives/2015/07/sharp-rise-in-euthanasia-for-psychiatric-patients/>

²⁶ Wendy Bonython, "From Oregon to Belgium to Victoria – the different ways suffering patients are allowed to die", *The Conversation*, 6 December 2017 <https://theconversation.com/from-oregon-to-belgium-to-victoria-the-different-ways-suffering-patients-are-allowed-to-die-88324>.

²⁷ Jones D.A., Gastmans C., MacKellar C. *(eds). "Euthanasia and Assisted Suicide: Lessons from Belgium." Cambridge University Press. 2017. United Kingdom.

²⁸ Parliament of Victoria, Legislative Council, Legal and Social Issues Committee, *Inquiry into end of life choices*, Final Report, June 2016, Minority Report, Chapter 4.

²⁹ Palliative Care Victoria, "Submission to the Legal and Social Issues Committee, Inquiry into End of Life Choices," July 2015 (Submission 236).

“Palliative Care” is defined as:

“... an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual ... Palliative care affirms life and regards dying as a normal process, and it intends to neither hasten nor postpone death. Palliative care offers a support system to help patients live as actively as possible until death.”³⁰

Associate Professor Ian Haines, MBBS is a medical oncologist and palliative medicine specialist who contributed publicly to the discussion during the Victorian Inquiry and made the following observations:

“As an oncologist with 35 years’ full-time experience, I have seen palliative care reach the point where the terminally ill can die with equal or more dignity than euthanasia will provide. It is now very effective and increasingly available for two of the three possible ways of dying, outside of sudden unexpected death, which are advanced cancer and chronic relapsing and remitting organ-specific disease such as heart or lung failure.”

“Palliative care is also available for people with chronic progressive cognitive diseases such as dementia. This is the fourth way of dying and perhaps the most feared of all.”

“Like Andrew Denton and others who have observed unbearable suffering in loved ones and the terrible failures of modern medicine in the past, I had once believed that euthanasia was the only humane solution.”

“I no longer believe that.”

“[Legalisation of assisted suicide] is not necessary, and ... it will inevitably increase the pressure, both stated and perceived, for some chronically ill patients to move on and stop being a burden.”

“I have received many euthanasia requests from patients and families over my 34 years in full-time oncology practice, some very passionate, but I have invariably found that they quickly disappear as reassurance and adequate medication doses provide the comfort that is desired and the newly exposed opportunities for patients and families to share deep and poignant moments of bonding and reflection, or nurse a new-born grandchild, or attend a wedding or a graduation.”³¹

³⁰ Radbruch, L; Leget, C.J.W.; Bahr, P.; Muller-Busch, C.; Ellershaw, J.; De Conno, F; Vanden Berghe, P., “Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care”, *Palliative Medicine*, 2015, p.5

³¹ Ian Haines “I believed that euthanasia was the only human solution. I no longer believe that”, *Sydney Morning Herald*, 20 November 2016.

Palliative Care Victoria has outlined the following statistics and information in relation to the benefits of palliative care:³²

“Appropriately resourced palliative care will provide the best care possible to improve the quality of life of people with a life-limiting illness, to respond to their needs and preferences, and to support them to die with dignity and in comfort.”

“Extensive research studies³³ have demonstrated a range of quality of life benefits for people receiving palliative care and their families including:

- Improved management of pain and other symptoms
- Increased likelihood of receiving care at their place of choice
- Increased likelihood of dying at home, where this is their preference
- Increased family support and satisfaction with the care provided
- Greater emotional support
- Improved communication with families
- Significant improvements in quality of life and mood, and
- Less aggressive care at the end of life but longer survival.”³⁴

An open letter written to Members of Parliament by Australian Palliative Care Professionals pointed out the misconceptions surrounding palliative care, and affirmed that palliative care, in all but extreme cases, relieves pain and suffering for those with terminal illnesses:

“Current Australian data indicates that no more than 2 in every 100 Palliative Care patients would be in moderate or severe pain at the end of life. In these unusual cases where when all other methods of palliation for pain and other symptoms is inadequate, and if the patient agrees, palliative sedation therapy is available to provide adequate relief of suffering.

This is not just a ‘pharmacological oblivion’ as some have claimed. It is the careful management of pain and other severe symptoms through individualised medication plans at therapeutically recognised doses, and with dignified personal care, delivered by experienced doctors, nurses and allied health workers. Family and carers are also supported with emphasis on a holistic approach.

No one is abandoned and everyone can be assisted or supported in some way.”³⁵

³² Palliative Care Victoria, “Submission to the Legal and Social Issues Committee, Inquiry into End of Life Choices,” July 2015 (Submission 236).

³³ See further Palliative Care Victoria, “Submission to the Legal and Social Issues Committee, Inquiry into End of Life Choices,” July 2015 (Submission 236).

³⁴ Ibid.

³⁵ Available here: <http://www.healthprofessionalsayno.info>

The Minority Report of the Legal and Social Issues Committee *Inquiry into end of life choices - Final Report* in Victoria concluded as follows:

“In almost all cases where a patient experiences a great deal of pain, including terminal cases, the symptoms of that pain can be managed by current best practice in pain relief and palliative care. It is important to note that the capacity of health practitioners to manage the symptoms is increasing over time.

A number of expert practitioners in palliative care gave evidence to the Committee in relation to the frequency of cases in which it was possible to manage pain at the end of a patient’s life. While it is not possible to put a precise percentage on this proportion, the experts were unanimous in their assessment that it was rare that pain couldn’t be managed.”³⁶

It is important to note, in this regard, that whilst Victoria has recently enacted the Voluntary Assisted Dying Act 2017, it has the lowest rates of palliative care per capita in Australia, with only 0.7 FTE palliative carers per 100,000 patients.³⁷ The open letter described above called the introduction of assisted suicide and euthanasia while patients did not have access to the correct care “unethical.” Of the 49 recommendations made in the *Inquiry into end of life choices - Final Report*, 30 related to the improvement of palliative care funding and access, and only a single recommendation related to the introduction of assisted suicide.³⁸ Palliative Care Victoria requested an additional \$65 million per annum to implement the recommendations, but did not receive any of the funding it requested in order to improve this situation.³⁹ The Victorian Government has demonstrated that it prioritises assisted dying over and above meeting the funding needs of palliative care. The ACT Government should not follow suit.

Similarly to the threat to palliative care services, the legalisation of euthanasia and/or assisted suicide poses a threat to other types of care as well. In jurisdictions where assisted suicide has been legalised, health insurance companies have denied cover for patients for cancer treatment but offered to cover the cost of assisted suicide instead.⁴⁰ These stories challenge the idea that euthanasia and/or assisted suicide are matters of personal choice, affecting only those who decide to end their own lives. These cases demonstrate instead that providing the ‘choice’ of death to some limits the choices available to those who do not wish to die.

³⁶ Parliament of Victoria, Legislative Council, Legal and Social Issues Committee, *Inquiry into end of life choices*, Final Report, June 2016, Minority Report, beginning at p.343, Chapter 2.

³⁷ <https://www.aihw.gov.au/reports/palliative-care-services/palliative-care-services-in-australia/contents/palliative-care-workforce/specialist-palliative-medicine-physicians-and-nurses>

³⁸ Parliament of Victoria, Legislative Council, Legal and Social Issues Committee, *Inquiry into end of life choices*, Final Report, June 2016, beginning at p.xxix.

³⁹ <https://dr892t1ezw8d7.cloudfront.net/wp-content/uploads/2017/07/PCV-Seeks-65M-for-Palliative-Care-A4.pdf>

⁴⁰ Stephanie Packer in California was denied chemotherapy treatment by her health insurance company but offered to pay for assisted suicide <https://www.washingtontimes.com/news/2016/oct/20/assisted-suicide-law-prompts-insurance-company-den/> See also case of Barbara Wagner in Oregon – denied health cover but offered assisted dying <http://abcnews.go.com/Health/story?id=5517492&page=1>

5. Overseas experience also shows that where assisted suicide is legalised, it moves from being used in just the ‘rare’ cases that can’t be treated medically involving “unbearable suffering,” to many more cases

Evidence from overseas jurisdictions confirms that once euthanasia and/or assisted suicide are legalised, the number of deaths increases significantly from the time it is introduced.⁴¹

The number of deaths from ingesting lethal substances prescribed under Oregon’s Death With Dignity Act reached 135 in 2015, up 28.57% from 2014, continuing a steady rise since 1988, the first year of the Act’s operation when 16 people died under its provisions.⁴²

For example, Washington State’s *Death with Dignity Act* came into operation on 9 March 2009. The legislation is based on Oregon’s assisted suicide regime. The latest annual report with data from 2016 was published in September 2017. The latest data confirms that once assisted suicide is legalised use of it increases from year to year, seemingly without limit. In 2010 the first full calendar year of operation, some 87 prescriptions for lethal drugs were provided under the Act. By 2016 this had nearly tripled (288%) to 248. Prescriptions for lethal drugs increased by 15% from 2015 to 2016. Deaths from lethal drugs prescribed under the Act have nearly quadrupled (376%) from 51 in 2010 to 192 in 2016, increasing by 13.6% from 2015 to 2016 alone.

The Guardian reports that the ‘taboo’ against killing has been removed in the Netherlands,⁴³ and that ‘concerns have been raised that assisted death is becoming normalised.’⁴⁴ There were approximately 7,000 people euthanized by doctors in 2017, an increase from 4,188 cases of euthanasia in 2013.⁴⁵

Professor Theo Boer, a former supporter of euthanasia, has warned against legalising euthanasia, saying other jurisdictions should learn from the Netherlands.⁴⁶

“I used to be a supporter of the Dutch law. But now, with 12 years of experience, I take a very different view. Whereas in the first years after 2002 hardly any patients with psychiatric illnesses or dementia appear in reports, these numbers are now sharply on the rise. Cases have been reported in which a large part of the suffering of those given euthanasia or assisted suicide consisted in being aged, lonely or bereaved. Some of these patients could have lived for years or decades. Pressure on doctors to conform to patients’

⁴¹ Parliament of Victoria, Legislative Council, Legal and Social Issues Committee, *Inquiry into end of life choices*, Final Report, June 2016, Minority Report, beginning at p.343, Chapter 2.

⁴² Oregon Public Health Division, Oregon Death With Dignity Act: Data Summary 2016, Figure 1, p.4, <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf>

⁴³ <https://www.theguardian.com/world/2017/nov/09/any-taboo-has-gone-netherlands-sees-rise-in-demand-for-euthanasia>

⁴⁴ Ibid.

⁴⁵ <https://www.theguardian.com/world/2018/mar/12/dutch-prosecutors-investigate-euthanasia-cases-sharp-rise-doctor-assisted-deaths-netherlands>

⁴⁶ <http://www.dailymail.co.uk/news/article-2686711/Dont-make-mistake-As-assisted-suicide-bill-goes-Lords-Dutch-regulator-backed-euthanasia-warns-Britain-leads-mass-killing.html>

– or in some cases relatives’ – wishes can be intense. Pressure from relatives, in combination with a patient’s concern for their wellbeing, is in some cases an important factor behind a euthanasia request. Not even the review committees, despite hard and conscientious work, have been able to halt these developments.”⁴⁷

6. The link between legalisation of assisted suicide and suicide rates in a jurisdiction and mixed messages about ‘suicide prevention’

Legalising euthanasia is problematic in a jurisdiction which on the one hand, invests considerable resources into suicide prevention, and on the other encourages suicide nevertheless for some of its citizens.

The issue is also challenging from the perspective of suicide contagion,⁴⁸ given that once a jurisdiction legalises assisted suicide, the message conveyed by the government is necessarily a positive one about suicide in some circumstances. The implications of this for citizens with suicidal ideation must be taken into account as part of the discussion around the consequences of legalising euthanasia and assisted suicide.

A study conducted by David Albert Jones and David Paton and published in 2015 found that “[l]egalising [physician assisted suicide] has been associated with an increased rate of total suicides relative to other states and no decrease in non-assisted suicides. This suggests either that PAS does not inhibit (nor acts as an alternative to) non-assisted suicide, or that it acts in this way in some individuals but is associated with an increased inclination to suicide in other individuals.”⁴⁹

Indeed, in Oregon, where assisted suicide was legalised in 1997, a report prepared by the state department has found that the suicide rate has been increasing since 2000,⁵⁰ and that in 2014, Oregon’s suicide rate was 43.1% higher than the national average. These figures do not include the number of deaths related to the *Death with Dignity Act*, as these are not classified as suicides under the law in Oregon.

As Professor Margaret Somerville has asserted, “state sanctioned assisted suicide endorses suicide as an appropriate response to suffering and suicide is contagious.”⁵¹

⁴⁷ Ibid.

⁴⁸ Gould, M.S.; Lake, A.M., “The Contagion of Suicidal Behaviour” in Institute of Medicine and National Research Council, 2013, *Contagion of Violence: Workshop Summary*, Washington D.C: The National Academies Press. Can be accessed here: <https://www.suicideinfo.ca/resource/the-contagion-of-suicidal-behavior-2/>

⁴⁹ D Jones and D Paton, “How does Legalisation of Physician Assisted Suicide Affect Rates of Suicide?” 108 *Southern Medical Journal* (2015): 599-604 at p.599.

⁵⁰ X Shen and L Millet, *Suicides in Oregon: Trends and Associated Factors. 2003-2012* (Oregon Health Authority 2015)

<http://www.oregon.gov/oha/ph/DiseasesConditions/InjuryFatalityData/Documents/NVDRS/Suicide%20in%20Oregon%202015%20report.pdf>

⁵¹ Margaret Somerville, “The Importance of Stories in the Euthanasia Debate” ABC Religion and Ethics, 28 February 2017, which can be found here: <http://www.abc.net.au/religion/articles/2017/02/28/4627671.htm>

7. The complexity of depression and euthanasia

“Depression raises the question about how the depression interacts with decision making. What safeguards need to be in place to protect people from making decisions that might be affected in the short term by a depressive mood that might be manageable or treatable with additional support? Great care needs to be taken where a person is suffering from depression and is seeking either euthanasia or assisted dying.”⁵²

Research by Linda Ganzini has established that one in six people who died under Oregon’s law had clinical depression.⁵³ Depression is supposed to be screened for under the Act, however it is not compulsory. In 2016, less than one in twenty five (3.75%) who died under the Oregon law were referred by the prescribing doctor for a psychiatric evaluation before writing a script for a lethal substance.

In 2011, Dr Charles J. Bentz of the Division of General Medicine and Geriatrics at Oregon Health & Sciences University explained the ways that Oregon’s physician assisted suicide law is not working well. He cited the example of a 76-year-old patient he referred to a cancer specialist for evaluation and therapy. The patient was a keen hiker and as he underwent therapy, he became depressed partly because he was less able to engage in hiking. He expressed a wish for assisted suicide to the cancer specialist, who rather than making any effort to deal with the patient’s depression, proceeded to act on this request by asking Dr Bentz to be the second concurring physician to the patient’s request. When Dr Bentz declined and proposed that instead the patient’s depression should be addressed the cancer specialist simply found a more compliant doctor for a second opinion. Two weeks later the patient was dead from a lethal overdose prescribed under the Act.⁵⁴

Dr Bentz concludes that ‘[i]n most jurisdictions, suicidal ideation is interpreted as a cry for help. In Oregon, the only help my patient got was a lethal prescription intended to kill him.’ He urges other jurisdictions ‘Don’t make Oregon’s mistake’.⁵⁵

There is no model from any jurisdiction that has legalised assisted suicide and/or euthanasia for adequately ensuring that no person who is assisted to commit suicide or killed directly by euthanasia is suffering from treatable clinical depression or other forms of mental illness that may affect the capacity to form a competent, settled, determination to die by assisted suicide or euthanasia. Jurisdictions like Oregon that provide for optional referral for psychiatric assessment manifestly fail to identify all cases of clinical depression.

⁵² Parliament of Victoria, Legislative Council, Legal and Social Issues Committee, *Inquiry into end of life choices*, Final Report, June 2016, Minority Report, beginning at p.343, Chapter 3.

⁵³ Linda Ganzini et al., “Prevalence of depression and anxiety in patients requesting physicians’ aid in dying: cross sectional survey”, *BMJ* 2008; 337: a1682
http://www.bmj.com/highwire/filestream/384131/field_highwire_article_pdf/0.pdf

⁵⁴ Charles Bentz, “Oregon’s assisted suicide law isn’t working”, *The Province*, December 5 2011,
<http://blogs.theprovince.com/2011/12/05/provinceletter-icbc-egypt-assisted-suicide-oregon-christmas-pre-marital-sex/>

⁵⁵ *Ibid.*

The only jurisdiction which has required a psychiatric assessment for each case of euthanasia was the Northern Territory. However, even with such a 'safeguard' in place, this system signally failed to adequately identify depression, demoralization or other psychiatric issues which may have been treatable in all four cases of persons killed by former doctor Philip Nitschke under the Rights of the Terminally Ill Act 1995 (NT).⁵⁶

Compulsory referral to a psychiatrist, who may have never seen the person before, for a single brief assessment of whether the person's decision-making capacity about assisted suicide or euthanasia is affected by depression or other psychiatric factors is clearly an inadequate safeguard and will not make assisted suicide 'safe'.

In 2015, under Washington State's Death With Dignity Act, based on Oregon's, only 4% of those given a lethal prescription were referred to a psychiatrist or psychologist for evaluation. In some cases, the prescribing doctor knew the patient for less than a week before writing the prescription, and in just over half the cases (51%) the doctor knew the patient for less than 25 weeks.⁵⁷

Another study by Ganzini et al. found that "in a study of 321 psychiatrists in Oregon only 6% were very confident that in a single evaluation they could adequately determine whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide."⁵⁸ Similarly, other studies also show that "physicians are not reliably able to diagnose depression, let alone to determine whether depression is impairing judgment."⁵⁹

"A guidebook for health care professionals written by the Oregon University Center for Ethics advises physicians to refer all cases requesting suicide for psychiatric evaluation, even though physicians are not legally required to do so. Oregon physicians are not following that advice. The percentage of cases referred for psychiatric evaluation dropped from thirteen percent in the eight years between 1998 and 2005 to four percent in 2006."⁶⁰

8. Women are uniquely at risk for assisted suicide

Advocates for assisted suicide continually cite the importance of having a 'choice' to end their lives, but they often overlook the fact that end of life decisions are not made in a vacuum. Though there are influences that affect all individuals faced with end-of-life decisions,

⁵⁶ Kissane, D.W.; Street, A.; Nitschke, P.; "Seven Deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia", *The Lancet*, Volume 352, October 3, 1998.

⁵⁷ Washington State Department of Health 2015 Death with Dignity Act Report, p.4, <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2015.pdf>, Table 3 on p.8.

⁵⁸ Linda Ganzini et al., "Attitudes of Oregon psychiatrists towards physician-assisted suicide", *American Journal of Psychiatry* 1996: 153:1469-75, <http://ajp.psychiatryonline.org/doi/abs/10.1176/ajp.153.11.1469>

⁵⁹ George E. Murphy, *The Physician's Responsibility for Suicide. II. Errors of Omission*, 82 *Annals Internal Med.* 305 (1975), cited in Herbert Hendin and Kathleen Foley, "Physician-Assisted Suicide in Oregon: A Medical Perspective" 106 *Mich. L. Rev.* 1613 (2008), at p.1623.

⁶⁰ *Ibid* Hendin, H. and Foley, K. at pp.1623-1624.

research is showing that women are especially susceptible to assisted suicide due to multiple factors, otherwise known as 'gendered risks'.⁶¹

The first of these factors is the typically longer life span of women. Because they live longer, women are more likely to suffer from disease and disability, as well as elder abuse. The ALRC has found that women are much more likely to suffer elder abuse than men – as many as 20% of Australian women are victims.⁶²

Women are also more likely to have lost their spouse and living alone. The resulting loneliness is a major factor in older adult suicides as shown in this 2013 Australian psychological study.⁶³ Without their spouse, women may lose the will to live.

Economic disadvantage is another factor affecting women. Women have fewer economic resources when they are older, the time when decisions about assisted suicide are most likely to occur. The entrenched economic disadvantage limits their options for care and means they are more likely to face other financially related adversities.

Women are also more likely to have to pay for care than men due to their male partners and families being less likely to care for them. Even if they have family members to take care of them, women may feel that they are a burden because of the drain they put on their family's finances.

In a study of assisted suicides where the majority of cases were women, the fear of being a burden was a prominent reason for deciding for death. The ethic of self-sacrifice was summed up by a friend of one of the suicides, who said: "She felt it was a gift to her family, sparing them the burden of taking care of her."⁶⁴

9. The legalisation of assisted suicide and euthanasia poses a threat to religious freedom

There are also creeping threats to religious freedom in jurisdictions where euthanasia has been legalised. A Catholic nursing home in Belgium was recently fined EUR 6,000 for refusing to permit one of its residents to be euthanized on its premises.⁶⁵

⁶¹ Rachael Wong, "We need to address questions of gender in assisted dying", *The Conversation* <https://theconversation.com/we-need-to-address-questions-of-gender-in-assisted-dying-85892>

⁶² Australian Law Reform Commission, *Elder Abuse – A National Legal Response: Final Report*, ALRC Report 131, May 2017, p. 37

https://www.alrc.gov.au/sites/default/files/pdfs/publications/elder_abuse_131_final_report_31_may_2017.pdf

⁶³ De Leo, D.; Draper, B.M.; Snowdon, J.; Kolves, K., "Suicides in older adults: a case control psychological autopsy study in Australia", *Journal of Psychiatric Research*, July 2013, Volume 47, Issue 7, pp.980-988.

⁶⁴ Canetto, S.S.; Hollenshead, J.D., "Gender and physician-assisted suicide: an analysis of the Kevorkian cases 1990-1997", *Omega*, 2000, Volume 40, Issue 1, pp. 165-208 at p.180.

⁶⁵ Desanctis A. "California Religious Conscience Violations Make the U.S. Sound a Lot like Belgium." *National Review*. 8 July 2016.