

Submission

to the

**Parliament of Western Australia
Joint Select Committee
on
End of Life Choices**

from

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23rd October 2017

Ms Amber-Jade Sanderson
Chair, Joint Select Committee on End of Life Choices
Parliament of Western Australia
Harvest Terrace, Perth, 6005

23rd October 2017

Dear Ms Sanderson,

Thank you for the opportunity to contribute to the Standing Committee on End of Life Choices' consultation. I congratulate the Western Australia parliament for establishing this important review.

There are significant opportunities for the Parliament of Western Australia to update and integrate legislation and regulation about end of life choices. For example, the *Guardian and Administration Act 1990* (as amended) gives recognition to advance care directives, but overlooks an integrated approach for advance care *planning*, which encompasses far more than the document itself.

However, this submission focuses on an end of life choice which a great majority of Western Australians believe should be available, but currently is not: assisted dying.

I run DyingForChoice.com, an information service promoting facts and reason to counter extensive misinformation about end of life choices, especially in regard to lawful assisted dying. I am a past President and CEO of Dying With Dignity Victoria Inc, past and Foundation Chairman and CEO of national umbrella group YourLastRight.com Ltd, and a past President of the World Federation of Right To Die Societies, Inc. As a former primary medical researcher, I continue to keep abreast of health issues from a range of perspectives, including ethics, practice and research. I hold a literature database of over 7,000 professional journal and other articles on assisted dying and related topics.

This submission:

- Discusses the empirical evidence demonstrating the need of assisted dying law reform;
- Provides evidence of the strong desire of Western Australians (and Australians in general) for responsible assisted dying legislative reform;
- Presents primary research evidence that refutes supposed 'slippery slope' arguments advanced against assisted dying law reform;
- Explains examples of unpersuasive arguments and misinformation commonly used by opponents, and how they fail, including acknowledgement from opponents that they do indeed fail;
- Outlines the major forms of assisted dying legislative frameworks in force around the world today; and
- Proposes a broad set of legislative alternatives for consideration and development into a specific Bill to go before the Western Australia legislature.

I would be pleased to appear before the Committee to discuss these matters and answer questions.

Yours sincerely



Neil Francis

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Terms of reference

To inquire into, consider and report [abridged]:

0. On the need for laws in Western Australia to allow citizens to make informed decisions regarding their own end of life choices, and, in particular, the Committee should —
 1. assess the practices currently being utilised within the medical community to assist a person to exercise their preferences for the way they want to manage their end of life when experiencing chronic and/or terminal illnesses, including the role of palliative care;
 2. review the current framework of legislation, proposed legislation and other relevant reports and materials in other Australian states and territories and overseas jurisdictions;
 3. consider what type of legislative change may be required, including an examination of any federal laws that may impact such legislation; and
 4. examine the role of Advance Health Directive, Enduring Power of Attorney and Enduring Power of Guardianship laws and the implications for individuals covered by these instruments in any proposed legislation.

Definitions

For the sake of clarity, the following terms are defined.

Euthanasia

The combination of the Greek “eu” and “thanatos” (ευ θανατος) simply means ‘good death’. Note that the term itself does not define what a good death encompasses. The term is also silent on how a ‘good death’ might be achieved despite the attempts of some commentators such as Professor Margaret Somerville to attempt to assert *method* (one person administers a lethal substance to another person, or a person self-administers) into the definition (Somerville 2014). It simply means ‘good death’.

Passive euthanasia

Withholding or withdrawing life-sustaining treatment, or the voluntary refusal of food and fluids. The term ‘passive euthanasia’ is vigorously debated amongst both healthcare practitioners and scholars due to its included and sometimes pejorative term ‘euthanasia’, although that term simply means ‘good death’.

Voluntary euthanasia (VE)

Assistance to a good death has been voluntarily chosen by the person seeking the death (i.e. without undue influence).

Active voluntary euthanasia (AVE)

One person administers a lethal substance to another person to achieve a good death, at the specific request of the recipient.

Non-voluntary euthanasia (NVE)

A person’s death is hastened without a current explicit request from the patient.

Physician-assisted dying (PAD)

A doctor supplies medication (or a prescription for medication) for a lethal substance to be self-administered by a patient to him or herself to achieve a good death. There is considerable debate amongst scholars as to whether this is suicide or not. Under the Oregon and Washington *Dying With Dignity Acts* it is classed *not* as a suicide.

Assisted suicide (AS)

One person (not necessarily a doctor) assists another person to self-administer a lethal substance to achieve a good death of the recipient, at the recipient’s explicit and voluntary request.

Assisted dying (AD)

A person is rendered assistance via AVE, PAD or AS, to bring about what is for that person a good death. This expression will be used throughout this submission to indicate that a range of forms assisted dying may apply.

Barbara Roberts



Former Governor
Oregon

“I believe strongly that what we can talk about we can make better and I don’t think that anything is much more clear about this [assisted dying] law than what is happening in Oregon.

More people are in hospice in this State than almost any State in the nation. Our pain control management is better than almost any State in the nation, maybe any State. More people die at home than in hospitals in Oregon.

Everything about the process has made dying better in Oregon for all kinds of citizens, whether they use the law and take advantage of it, or whether they don’t. And so it has given them dignity, it has given them choices, it has given them a sense of self-control.

Oregon proves what happens when you make the law and the compassion come together.”

Part A: Introduction

This section addresses Terms of Reference items 0, 1, 2 and 3.

Assisted dying is where a person is rendered assistance, via active voluntary euthanasia, physician-assisted dying or assisted suicide, to bring about what is for that person a good death.

A critical principle

A critical principle must be established at the outset: the person and only the person may make a decision to elect for an assisted death for themselves. *No person or organisation may make a decision for assisted dying on behalf of someone else.*

Decision-making biases to be avoided

During its hearings, deliberations and report-writing, it is important that the Committee and its Secretariat remains attuned to potential significant sources of bias in decision making. The Committee will have received a large number of submissions which may give rise to unintended biases. Three key biases are discussed here.

Potential bias 1: *Strong emotional language* diminishes critical faculties

Strong and emotional language and expressed certainty regarding 'slippery slopes' and how 'the vulnerable' will supposedly be 'at risk' from assisted dying law reform is a common claim.

However, arguments that arouse strong emotions can reduce the engagement of critical thinking (Blanchette 2013) and make weak 'slippery slope' arguments appear strong (Quraishi & Oaksford 2013). Interpretive biases are particularly linked with anxiety and the perception of risk (Blanchette & Richards 2010), which the Committee and Secretariat may experience as a result of strong (and untrue) statements appearing in numerous submissions.

Potential bias 2: *Repetition* doesn't make a falsehood true

The inquiry will receive a large volume of submissions opposing assisted dying law reform, making a range of highly repetitious claims. Indeed, from Victoria's experience it is clear that many of these submissions are form letters in which groups of people have been given 'talking points,' and cut and pasted selections into their own submissions.

Repetition increases the susceptibility of recipients to accepting misinformation, and to perceptions of accuracy of the claims (Bright-Paul & Jarrold 2012; Foster et al. 2012).

Potential bias 3: *Use of 'authorities'* as undeserved 'evidence' cues

Appeals to perceived 'authority' or 'expertise' are common when there is a diversity of views on a topic (Furedi 2015), and the Committee will have received submissions to this inquiry from a number of medical and religious 'authorities'. However, such appeals are problematic. Where an authority's views are opinion-based rather than validly founded on direct empirical research, they are only slightly more accurate than chance (Mizrahi 2013). Importantly, the views of 'expert authorities' can have the effect of inappropriately excluding options, and can result in questionable political judgements (Robinson & Goren 1997).

In this submission, I report a number of cases where 'authorities', such as those holding the title of Professor, or professional associations, have made claims contradicted by appropriate empirical evidence.

Clearly, 'authority' status does not preclude misunderstanding of 'evidence' and misuse of misinformation. The Committee and Secretariat must remain vigilant so as not to be misled by false claims, by virtue of the claimant's apparent 'expertise'.

Recommendation 1

That the Committee and its Secretariat vigilantly avoid inadvertent bias in its decision making that may result from (a) emotions diminishing critical evaluation, (b) repetition giving rise to perceptions of validity and accuracy of misinformation, and (c) appeals to 'authority' giving rise to false impressions of 'evidence' quality, and to inappropriate exclusion of options.

Assisted dying law reform is necessary

The Committee will have received a large number of submissions clearly showing that the experience of a bad death is not uncommon, and that many would have liked the *option* of an assisted death, whether they would have used it or not.

The quality of palliative care in Australia is world-class and a great credit to its dedicated practitioners. Independent global research (The Economist 2010) has found the overall quality of end-of-life care in Australia to be equal to that in the UK—the world's gold standard and birthplace of the palliative care discipline—and ahead of all other countries studied (Figure 1).

An increasing number of studies demonstrate the efficacy of palliative care in improving quality of life at end of life (Bakitas et al. 2009; Casarett et al. 2008; Follwell et al. 2009; Garcia-Perez et al. 2009; Penrod et al. 2010; Temel et al. 2010; Yennurajalingam et al. 2011).

However, it is **equally well-recognised that even the best palliative care can't always alleviate severe symptoms** of the dying process, causing intolerable suffering for some at the end of life. **Both Palliative Care Australia and the Australian and New Zealand Society for Palliative Medicine acknowledge this fact:**

"While pain and other symptoms can be helped, complete relief of suffering is not always possible, even with optimal palliative care." (Palliative Care Australia 2006)

"It is simplistic to argue that palliative care can remove all suffering at the end of life." (Spruyt 2006) [then President of the Australian and New Zealand Society of Palliative Medicine]

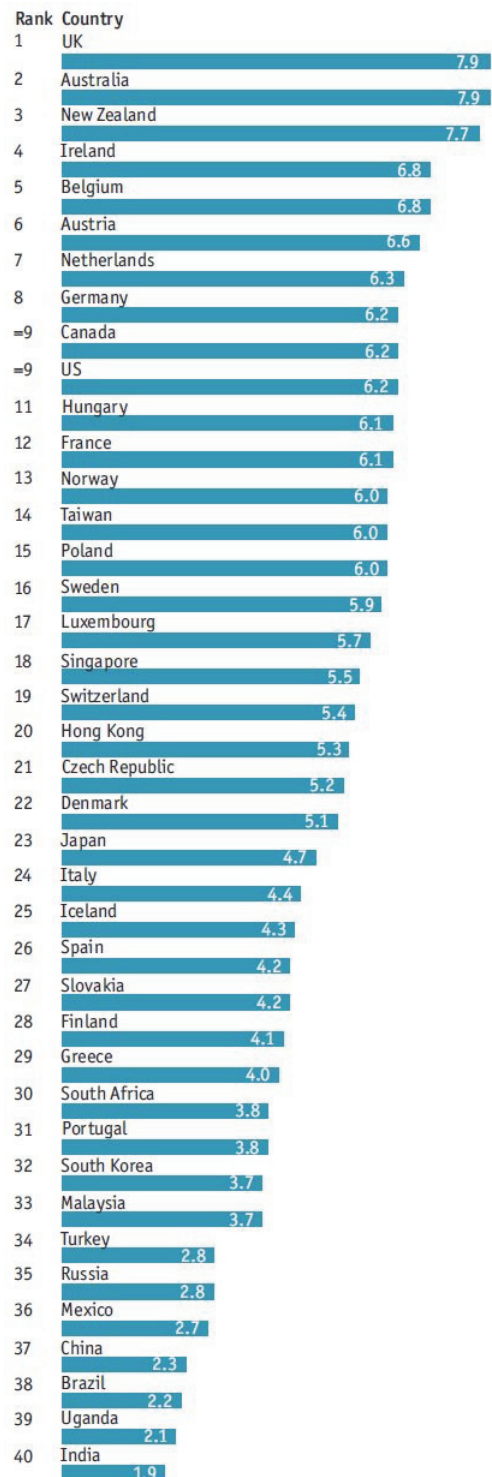


Figure 1: The Economist ratings of 40 countries' quality of end-of-life care. Australia is number 2. Source: The Economist (2010)

"...palliative care can control most symptoms and augment patients' psychosocial and spiritual resources to relieve most suffering near the end of life. On occasion, however, severe suffering persists; in such a circumstance a patient may ask his physician for assistance in ending his life by providing physician-assisted death" (American Academy of Hospice and Palliative Medicine 2007) [AAHPM, like Palliative Care Australia, maintains a stance of 'studied neutrality' towards assisted dying.]

Experience reflected in the peer-reviewed medical literature agrees:

"Some patients approaching death have refractory symptoms." (Cowan & Palmer 2002)

"...patients near the end of life may experience intolerable suffering refractory to palliative treatment." (Mercadante et al. 2009)

"Despite the progress made in palliative medicine in terms of symptom control, there are still many patients who have intractable symptoms, because the treatment is either ineffective or intolerable." (Maltoni et al. 2012)

"Patients with advanced cancer often suffer from multiple refractory symptoms in the terminal phase of their life." (Barathi & Chandra 2013)

"Palliative care cannot remove every kind of distress." (Noble 2013)

"Relief of suffering remains an elusive goal for many patients." (Orentlicher 2013)

Equally, the past President of the AMA, Dr Brendan Nelson, acknowledges that there is:

"...a small group of patients for whom no amount of medical treatment is going to relieve their suffering." (Nelson 1994)

Palliative and medical care can never address all profound suffering at the end of life, regardless of funding or organisation: some kinds of suffering have no relevant or effective medical interventions. To claim that it can is a *"monstrous arrogance"* (Hain 2014) and *"represents the last vestiges of [medical] paternalism"* (Horne 2014). To expect perfection in every circumstance is unrealistic and unfair.

"It is clear that improving palliative care will not remove the need for legalizing assisted dying, and that legalizing assisted dying need not harm palliative care." (Downar, Boisvert & Smith 2014)

No amount of funding or organisation will allow palliative care to relieve all intolerable suffering at the end of life. To expect that it might is fanciful.

Consequences of denying lawful assisted dying choice

Some dying individuals experience extreme and unwanted suffering in their last chapter, as will have been amply documented in numerous submissions to the inquiry.

For those wanting to avoid intense and prolonged end-of-life suffering, the consequences can be dire. On average, four Australians over the age of 70 suicide every week (Australian Bureau of Statistics 2010). While not all elderly Australians are terminally ill, not all terminally ill Australians are elderly, so the rate serves as a useful proxy measure. The evidence from Victoria is more specific: at the

Victorian Parliament's inquiry, the state Coroner reported from detailed psychiatric post-mortem of suicide cases that 8.5% of suicides in Victoria are of people facing intolerable and unrelievable suffering at the end of life (Gray 2015).

The Bureau of Statistics, coroners and researchers agree that the rate is underreported (De Leo et al. 2010). Suicide methods used are often violent and undignified, traumatising emergency response teams and families.

In the UK it has been estimated that around one in ten suicides is in the context of a terminal or severe chronic illness (Bazalgette, Bradley & Ousbey 2011), and 1 in 10 suicides in the USA has been determined to occur without an identifiable mental disorder (Oquendo & Baca-Garcia 2014).

The National Violent Death Reporting System (NVDRS) in the USA, which conducts extensive and detailed analysis of suicides and their precursors, has found that suicide circumstances differ considerably at different ages, with incurable and intolerable illness by far the most common reason amongst seniors in Oregon (Figure 2), where assisted dying is legal (Shen & Millet 2015).

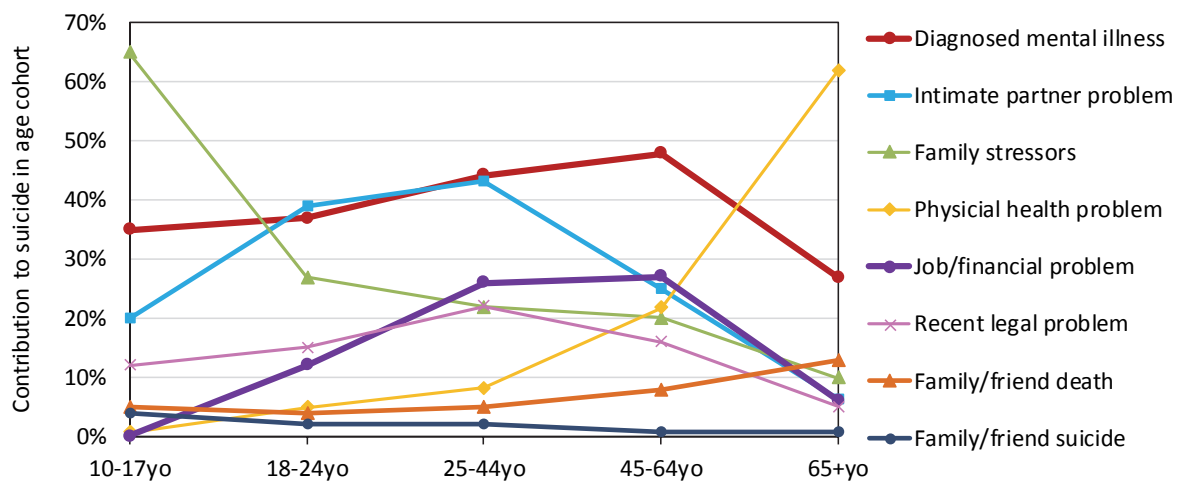


Figure 2: Oregon suicide circumstances 2003-2012
Sources: Shen & Millet (2015), personal correspondence with Oregon DHS.

Indeed, assisted dying opponents acknowledge that dying patients can suicide:

"Well currently people do, you know, have the option of suicide, that's obviously something we don't encourage. But that is a [sic] option." Dr Gerald McGushin representing AMA Tasmania (McGushin 2014)

"I mean, everybody's got that right [to suicide] in one sense in that suicide is not a crime; what is a crime is assisted suicide..." Prof. Margaret Somerville (Somerville 2007)

*"Let's face it, it would have been quite possible for John Elliott, as tragic and difficult as the circumstances are, to have taken his own life here in Australia and I would never suggest - obviously everything I've said is totally contrary to that idea."*¹ Dr Greg Pike, Southern Cross Bioethics Institute (Pike 2007)

"I acknowledge that many ageing persons could autonomously decide to end their own lives according to their own sense of a good life and a good death, whatever the law was."
Fr Frank Brennan, Jesuit Priest and legal scholar (Brennan 2009)

¹ Dr John Elliott was a Sydney doctor with multiple myeloma who travelled to Switzerland for an assisted suicide at Dignitas.

Former Speaker of the Victorian Legislative Assembly, the Hon. Ken Smith (Lib., Bass) and I spent a week in Oregon, USA, interviewing people about the state's Death With Dignity Act, which came into effect in 1997. Dr Hugo Richardson, a Board-certified palliative care specialist at the Oregon Health and Sciences University, said that *before* the Act:

"We saw many patients who felt they had reached the end of traditional treatments for their disease and that there were no options. We saw, at least in the health maintenance group where I was working, many more violent suicides among terminally ill patients. ... even though they were being provided with adequate palliative care, that life had become intolerable for them." (interview recording and transcript on record)

And since the Death With Dignity Act came into effect?

"In that same population of people ... I have seen no violent suicides."

Clearly, Western Australians, like people elsewhere, want a dignified alternative when end-of-life suffering has become too much to bear: to be able to alight, with compassionate assistance, from the train of indignity and suffering one or two stops before the inevitable terminus.

It is well-documented that the prohibition of a peaceful, doctor-assisted death drives some terminally ill individuals to suicide using violent and undignified means.

Overmedicalisation and institutionalisation of death

In the past, dying patients would often succumb quickly to illnesses such as pneumonia, known as 'the old man's friend'. Contemporary medicine, while providing effective relief from many formerly fatal conditions, is now characterised by the institutionalised prolongation of dying rather than living (Foley 1995; Melvin 2001), burdening patients with extreme levels of suffering (Grob 2007) from multiple morbidities (Banerjee 2015; Teunissen et al. 2007) and eroding traditional consolations involved in dying and bereavement (Seale 2000).

"Those same technologies that can save life can also prolong dying." (Kenny 2011)

"Death from malignant disease is rarely the calm, dignified process so often portrayed on stage and screen." (Hardy 2000)

"Skilled nursing care can maintain life in a frail, elderly patient whose general condition is such that a comparable state in an animal might well lead to prosecution of the owner." (Baker 1976)

"Life-prolonging medical technologies frequently not only fail to relieve suffering, but in a very real sense become a source of suffering itself." (Ekland-Olson 2014)

"Australians are not dying as they would wish. Surveys consistently show that between 60% and 70% of Australians would prefer to die at home, and that residential care facilities are their least preferred option." (Swerissen & Duckett 2015)

"Most people's conception of what constitutes a good death is something like the following: at an advanced age, one falls asleep peacefully in one's bed, preferably at home, more or less free from pain, if possible surrounded by one's relatives and close friends, accepting the fact"

that death is inevitable, in a clear state of mind, after having had the opportunity to balance one's life and to prepare thoroughly for the long goodbye, all in all satisfied with the life one has led, and while regretting some of the mistakes one has committed, hoping to leave behind a positive reputation." (Sterckx, Raus & Mortier 2013)

Death of the kind described by Sterckx and colleagues is increasingly elusive, frequently hindered by excessive medicalisation and institutionalisation. Assisted dying in limited circumstances is a key law reform that will help some Western Australians follow more closely their preferred death trajectory, consistent with their own beliefs, values and circumstances.

The mere availability of *choice* of assisted dying is itself good palliative care. It means that a dying individual can get on with living out the remainder of life, without having to worry about how bad tomorrow might be if there is no acceptable 'exit' plan. This is the clear evidence in jurisdictions where assisted dying is legal.

"I have had at least two patients now, their families claimed that they lived longer from knowing that they would have that control, they would have the strength to take another trip or to go ahead and eat even when their body told them they were not hungry because they knew they had that control back and they could now play out a few more things."

Dr Nicholas Gideonse, Medical Director, Oregon Health and Sciences University Richmond, has helped a handful of patients use the Death With Dignity Act.

Current normative practice favours medical interventionism, but in some circumstances interventions are unhelpful, are unwanted and can even exacerbate suffering.

Choice to die can be rational

Community perception of suicide is that acting to end one's life is irrational, ill-informed, impulsive, and the result of mental illness with or without concomitant substance abuse. In such cases the negative perceptions—and efforts to reduce suicide—are justified.

However, assisted dying cases are quite different. Medical presumption of mental impairment in suicide is diminishing (Rich 2014), with two types of suicide — irrational and rational — now widely accepted (den Hartogh 2016). In the face of refractory and intolerable symptoms at the end of life, most Australian doctors believe a request for hastened death can be rational, including 96% of NSW doctors (Baume & O'Malley 1994), 93% of Victorian doctors (Kuhse & Singer 1988) and 89% of South Australian doctors (Stevens & Hassan 1994). Amongst UK psychiatrists, 86% agree (Shah et al. 1998), as do 81% of USA psychotherapists (Werth & Liddle 1994), and 85% of USA mental health counsellors (Rogers et al. 2001).

It has been suggested by mental health experts that there are three components of a rational suicide: (1) the presence of an unremittingly hopeless condition, (2) a suicidal decision made as a free choice, and (3) the presence of an informed decision making process (Werth & Cobia 1995). These checks may be readily accommodated in legislation to permit assisted dying in restricted circumstances.

Coupled with full information from doctors about prognosis, available treatments and the time to reflect, a decision to hasten death is one which the overwhelming majority of Australians believe should be legally available.

Stances opposed to the *rational* pursuit of a peaceful death over-pathologise suffering (Rich 2014) and reveal medical paternalism (Parker 2013).

A choice to die in the context end-of-life suffering can be rational, and is distinct from irrational, ill-informed and impulsive acts.

Regulation of existing underground practice

Despite assisted dying's illegality in Australia, research reveals that it is widely practiced. Many Australian nurses have collaborated with doctors to provide assisted dying, and occasionally have even done so without consulting a doctor (Kuhse & Singer 1993). Nurses in New Zealand also provide assisted dying, sometimes without consulting a doctor (Malpas, Mitchell & Koschwanez 2015; Mitchell & Owens 2004).

"Euthanasia is common. It's practiced out of sight, under wraps, no regulation, no rules, no supervision." Prof. Peter Baum (Baum 2001)

Professor Baum's statement is borne out by scientific search. A national survey of Australian doctors in 1996 found that 1.9% of deaths were the result of voluntary euthanasia (VE) or physician-assisted dying (PAD) (Kuhse et al. 1997). By comparison, the rate in the Netherlands in 1995 (the closest year of empirical research data) was 2.6% (Onwuteaka-Philipsen et al. 2012). **The rate of medically assisted deaths in Australia, where the practice is *illegal*, was three quarters the rate of the Netherlands, where the practice is *legal*** (Figure 3).

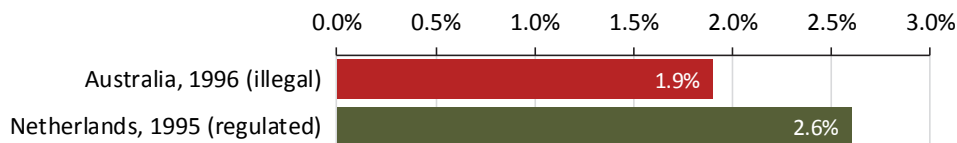


Figure 3: Assisted deaths as a proportion of all deaths — illegal assisted dying in Australia three quarters the rate of legal Dutch practice

Sources: Kuhse et al 1997, Onwuteaka-Philipsen et al 2012.

Similarly, Douglas and colleagues (2001) surveyed Australian surgeons, finding that more than a third had provided drugs with the intention to hasten patient death, and with more than half of cases lacking an express request from the patient.

Forms of medically assisted dying have been found to occur not only in Australia (and in the Netherlands where it has been lawful for decades), but in Belgium prior to its law reform (Chambaere et al. 2015); Switzerland, Denmark, Sweden and Italy (van der Heide et al. 2003); the UK (Seale 2009a; Seale 2009b); the USA (Back et al. 1996; Bonn 2000; Emanuel, Fairclough & Clarridge 1996; Lachman 2010; Schwarz 2003; Schwarz 2004); France (Riou et al. 2015); Norway (Forde & Aasland 2014; Forde, Aasland & Falkum 1997); and even in conservative Greece (Voultos, Njau & Vlachou 2010), Northern Island (McGlade et al. 2000) and Pakistan (Imran et al. 2014).

Indeed, "euthanasia is performed worldwide, regardless of the existence of laws governing it" (Gastmans et al. 2006), "in all countries studied" (Muller, Kimsma & Van Der Wal 1998), "albeit in a secretive manner" (Rosenfeld 2000) "in the privacy of their [doctor-patient] relationship" (Cassell 1995) and with repeated involvement among some physicians (Smith 2007).

The research evidence accords strongly with my own experience. Having delivered countless addresses at public events, conferences and meetings, I have lost count of the number of doctors who have approached me privately and said, in one way or another, "*of course* I've helped patients to die: just sometimes it's the right thing to do."

Occasionally, acknowledgement of assistance is more overt. In 1995, seven doctors in Melbourne publicly announced that they had helped patients achieve a peaceful, hastened death, and challenged then Victorian Premier Jeff Kennett to change the law. Later, the police and the medical registration board dropped their investigation into the seven doctors. Further cases have been outlined in publications, for example in 'Angels of Death' (Magnusson 2002) and 'A Good Death' (Syme 2008).

Even Dr Brendan Nelson, while President of the AMA, acknowledged that he had helped hasten the death of a patient. He stated that in the "2 percent of cases" where there was no hope of recovery, that "patients, their families and their doctors make those decisions [for euthanasia]" though clandestinely, because "technically it would be illegal" (Nelson 1995).

The evidence is irrefutable: there is underground assisted dying worldwide and it demonstrates that there is a profound need for assisted dying law reform to allow dying patients the right to seek a peaceful hastened death, and to protect doctors and nurses who provide that assistance. Law reform would also force assisted dying from the dark shadows, creating transparency and accountability around the process, which would then be open to discussion and improvement if required.



AMA President Dr Brendan Nelson acknowledges helping a patient die.

Intolerable and unrelievable patient suffering drives underground assisted dying across the world in jurisdictions where it is illegal, with no standards of practice or oversight.

Recommendation 2

That the Western Australia Parliament familiarise itself with the case for assisted dying law reform and the tragic consequences of denying Western Australians such a choice in the face of intolerable and unrelievable end-of-life suffering.

Part B: Overwhelming support

This section addresses Terms of Reference items 1 and 3.

Repeated and longitudinal research shows high levels of public desire for assisted dying law reform (Figure 4). National public opinion has been in the majority for around half a century, with very high levels for at least two decades (Francis 2012).

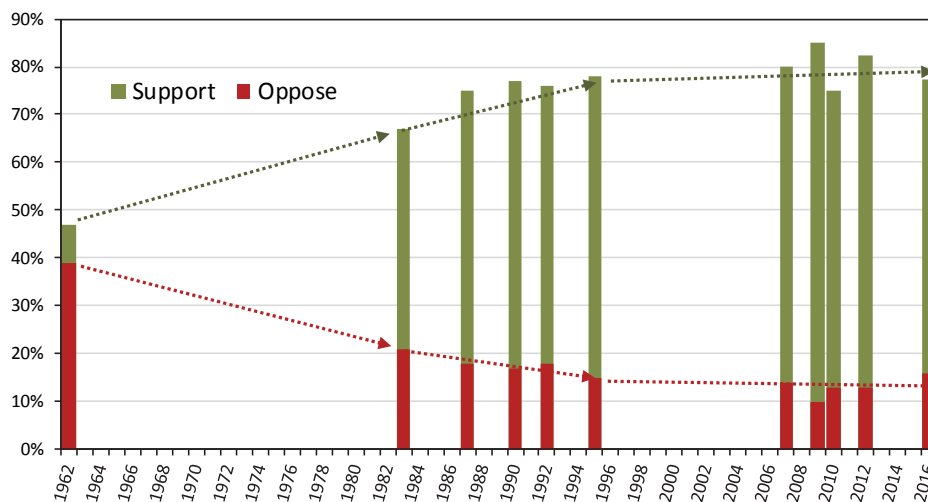


Figure 4: Australian public attitudes towards assisted dying over more than 50 years
Sources: Roy Morgan, ASRB, Newspoll, Australia Institute, Australian Election Study, VoteCompass

Support for assisted dying law reform in the 2012 study was high across age groups, education and region. The results are consistent with a 2013 study showing overwhelming support for personal end-of-life choice from 71% to 87% across a range of European countries, and a small majority (52%) in Greece (ISO Public 2012). A considerable majority said they would consider assisted dying themselves if faced with a serious incurable illness.

Australian voter attitudes by demographic

Impeccable Australian National University 'Australian Election Study' (AES) data for 2016 (Cameron & McAllister 2016), shows support for assisted dying amongst **Australia voters** at 77%, with 13% undecided and just 10%² opposed (Figure 5). Strong support (43%) is ten times greater than strong opposition (4%). There is no significant difference in overall attitudes between males and females.

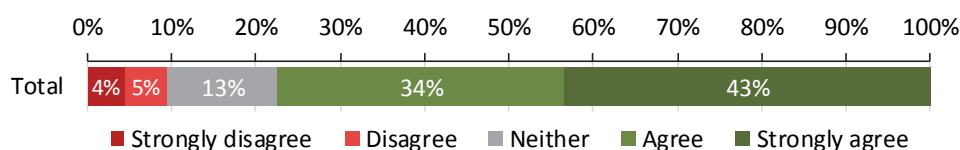


Figure 5: Australian voter attitudes toward assisted dying
Source: AES 2016

Support is high and opposition very low across all **age groups** (Figure 6).

² Rounding of reported figures may result in the appearance of data not matching by up to 1%.

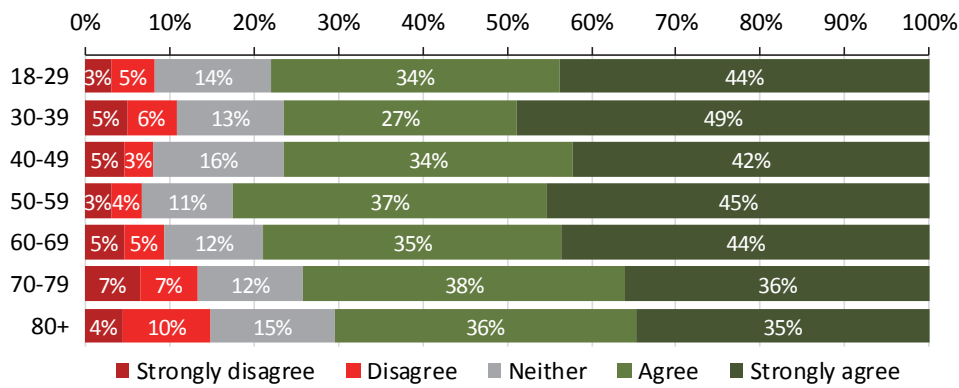


Figure 6: Australian voter attitudes toward assisted dying age group
Source: AES 2016

Support is high and opposition low in all **States** (Figure 7). Opposition is lowest in Western Australia.

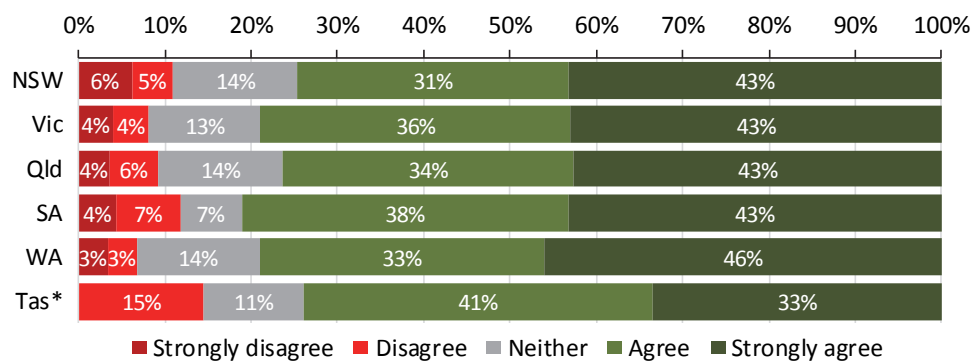


Figure 7: Australian voter attitudes toward assisted dying by State
Source: AES 2016. Note: Tas * Smaller sample size, result less reliable. Sample size of Territories too small to report data.

Support for assisted dying is in the majority across all **major religious groupings**, including amongst 74% of Catholics, 78% of Anglicans, 77% of Uniting Church members, and 89% of Australians with no religion (Figure 8).

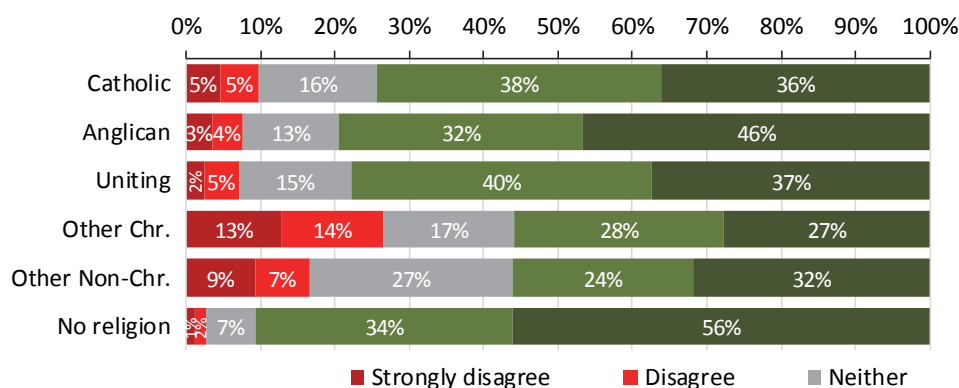


Figure 8: Australian voter attitudes toward assisted dying by religious affiliation
Source: AES 2016.

The strongest correlation with attitudes toward assisted dying is **religiosity** (ARI-6 scale) (Figure 9). Opposition to assisted dying is almost non-existent amongst religion Rejecters, Socialisers, Notionals (have a denominational affiliation but never attend services) and Occasionals. Only amongst Regulars (those who attend their own denominational services monthly or more often) and Devouts (weekly or more often), is there significant opposition. Regulars and Devouts combined comprise just 16% of Australian voters; Devouts just 11%.

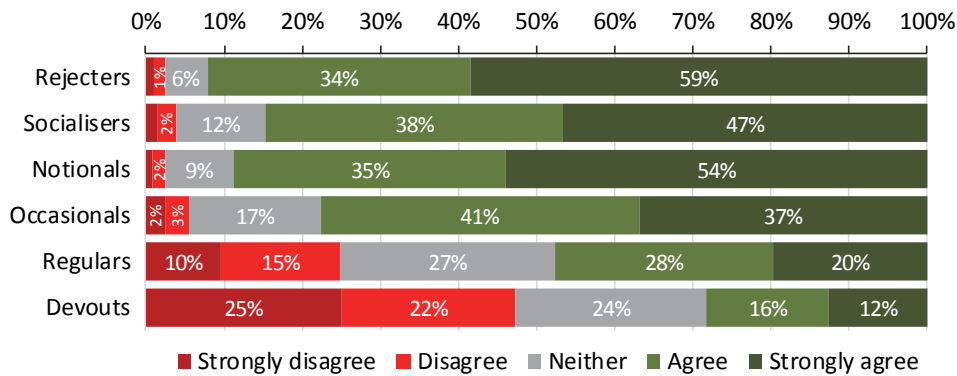


Figure 9: Australian voter attitudes toward assisted dying by religiosity (ARI-6)

Source: AES 2016

The variation is confirmed by a 2011 National Church Life Survey (NCLS Research 2011), which while hampered by a number of significant biases (Francis 2017h), found an even higher rate of opposition to assisted dying amongst those who attend religious services daily (Figure 10).

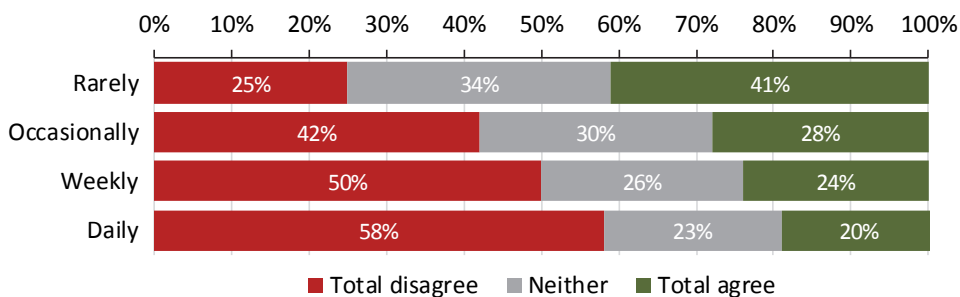


Figure 10: Attitudes of church attenders toward assisted dying by frequency of attending religious services

Source: NCLS Research 2011

Religiosity explains the variation in support for assisted dying by other measures, such as religious denomination, party voting and age group. For example, Figure 11 illustrates the religiosity of Australians amongst the major denominations. A quarter of Catholics and nearly half of Anglicans are Notionals, that is, they profess affiliation with the denomination, but never attend religious services — besides weddings, funerals and baptisms. Just 5% of Australians are committed (Regular or Devout) Catholics, and a tiny 1.6% are committed Anglicans.

Commitment is highest amongst the minor Christian denominations, but is still in the minority at 43%.

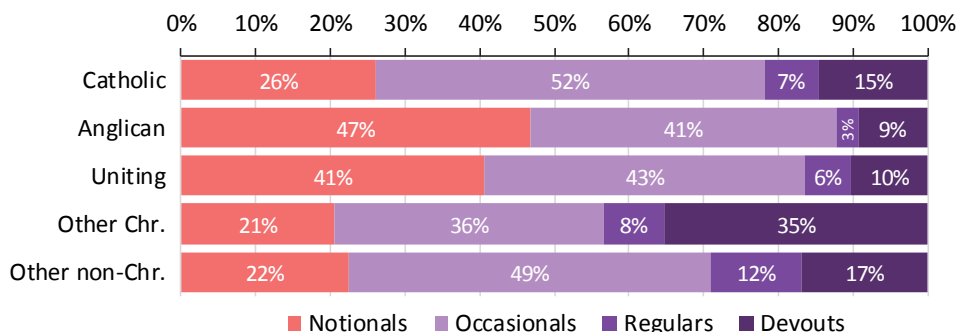


Figure 11: Strength of religious affiliation amongst Australians voters

Source: AES 2016

How is it that the great majority of Australians with a religion support assisted dying?

Having spoken with thousands of people about their support for assisted dying, I can report that those of faith very frequently say that despite their clerics' official opposition, personally they believe their God is compassionate and would not want them to suffer unnecessarily. Others go further and say that it would be an insult to squander their God's gift of reason to reach their own conclusion, and that He would understand a decision reached in good conscience.

Clearly, clerics are not representing the views of the vast majority of their flocks, and indeed seem to be alienating them, as **religiosity in Australia continues to fall** (Figure 12) (Francis 2017j).

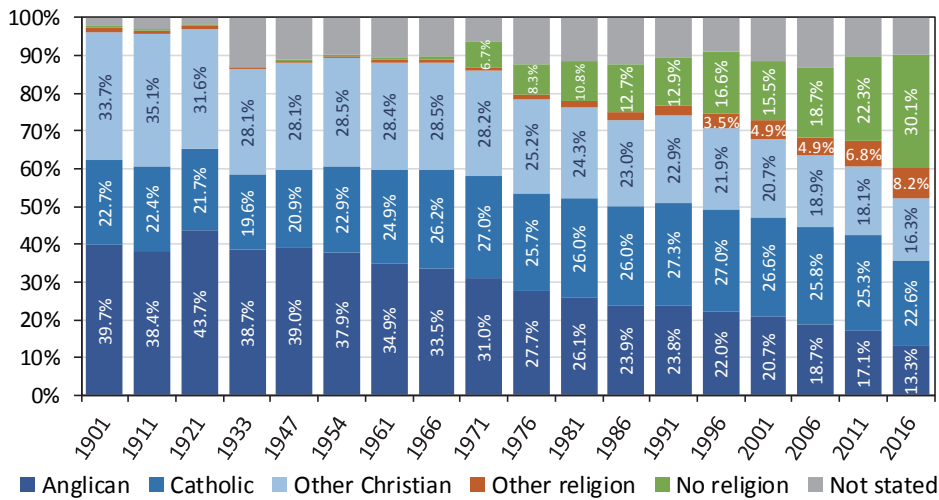


Figure 12: Australian population religious affiliation by census year

Source: Australian Bureau of Statistics

Support for assisted dying is high across the **political spectrum**, including a large majority of Greens (87%), Labor (80%), Coalition (77%) and minor and independents (71%) voters (Figure 13).

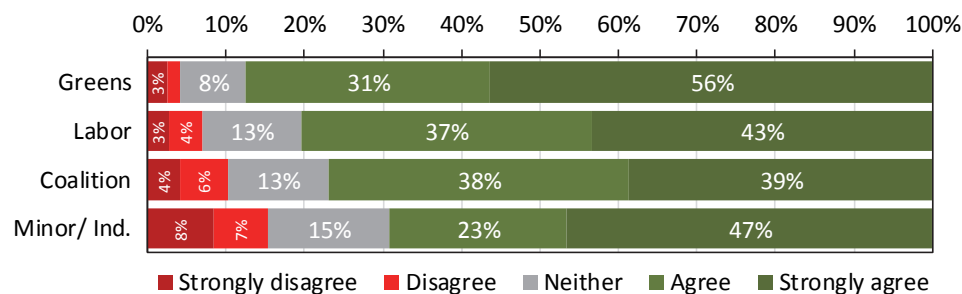


Figure 13: Australian voter attitudes towards assisted dying by party voting

Source: AES 2016. Note: First preference given for the House of Representatives in the 2016 Federal election.

Assisted dying a major issue for voters

Newspoll research (Figure 14) shows the relative importance of a range of public policy matters in 2012 (Francis 2012). Assisted dying was rated only less important than the NDIS, and boat arrivals that were highly contentious at the time and discussed widely in the media.

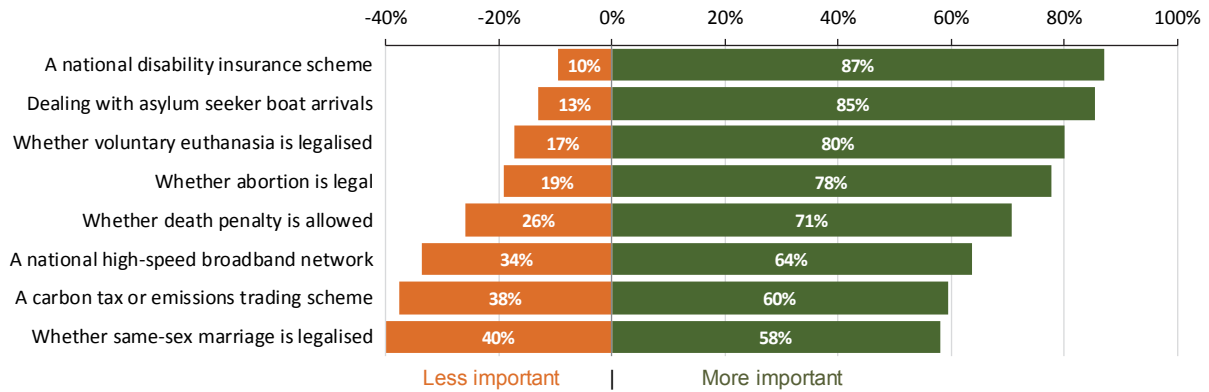


Figure 14: Personal importance of public policy areas to Australian adults

Source: Newspoll (Francis 2012). Notes: *Importance* only, does not imply support or opposition. Public attitudes toward same-sex marriage have changed markedly since 2012, while attitudes toward assisted dying have not.

More supporters than opponents think reform important

Legislators commonly believe that the issue of assisted dying legalisation is more important to those who oppose it than to those who support it. The myth is debunked by the Newspoll research, which found that a significantly higher proportion of supporters believe assisted dying legalisation is important (84%), than opponents thought its non-legalisation important (66%) (Figure 15). Opposers (29%) were roughly twice as likely as supporters (15%) to consider assisted dying *less important*.

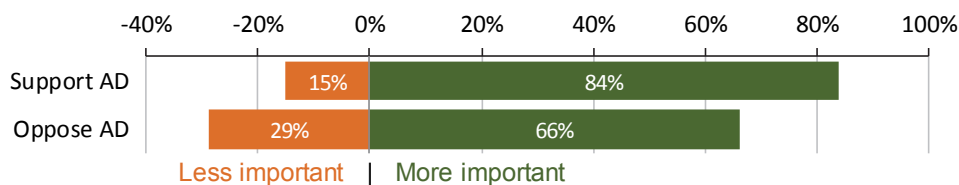


Figure 15: Personal importance of assisted dying policy to assisted dying (AD) supporters and opposers

Source: Newspoll (Francis 2012)

Voters will punish opposing MPs more

The 2012 Newspoll national survey was also the first to establish voters' intended behaviour in response to their 'usual' general election candidate supporting or opposing assisted dying, where the MP's stance is the opposite of the voter's (Figure 16).

Overall, a much larger proportion of the electorate said they would change their vote away from an MP who opposes assisted dying law reform (23%) than away from an MP who supports it (6%). The ratio of voting against an opposing versus supporting MP was 3.9 to 1 overall, 2.2 to 1 amongst Coalition voters, 4.6 to 1 amongst Labor voters, and 7.1 to 1 amongst Greens voters.

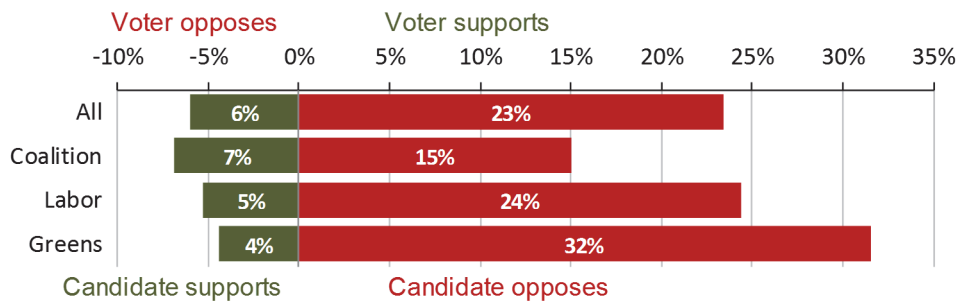


Figure 16: Proportion of the electorate who would change their first preference if 'usual' candidate's stance opposite to their own
Source: Newspann (Francis 2012)

Confirming this insight, a more recent study into several key marginal Victorian electorates, each currently held by Labor, found that there was a significant difference in potential vote changes for these MPs (OmniPoll 2017). For MPs supporting assisted dying law reform, there was a 51% upside versus 6% downside, or potential net difference of +45%. For opposed MPs the situation was almost reversed, with a 5% upside and a 53% downside; or potential net difference of -48% (Figure 17).

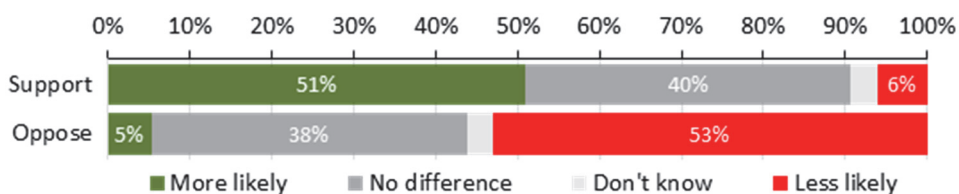


Figure 17: Likely change in *total* election vote for member 'position' on assisted dying
Source: OmniPoll 2017

A further study of three marginal Victorian Coalition-held seats also found 84% or more of voters support assisted dying, with around half of voters saying they would be less likely to support their Coalition MP at the next election if they did not support Victoria's *Voluntary Assisted Dying Bill* (Willingham 2017).

Not just a silver-hair issue

Assisted dying law reform is not just a matter for the silver hair brigade — Australia's elders. Every year, the Parliament of Victoria hosts Youth Parliament, a forum that helps the State's future leaders learn and practice the legislative process. Delegates prepare and introduce Bills into the Parliament and debate, amend and vote on them under official Parliamentary procedures.

Victoria's Youth Parliament has dealt with assisted dying law reform *four* times in the last decade (Figure 18).

- In 2006, Briana Packett and her team introduced an assisted dying Bill. It was debated and passed.
- In 2009, Kathryn White's team Bill was debated and passed.
- In 2011, James Farrier's team Bill was debated and passed.
- And in 2013, Tom Shields' team Bill, like the others, was also debated, sent to committee, revised, went to a vote and passed.

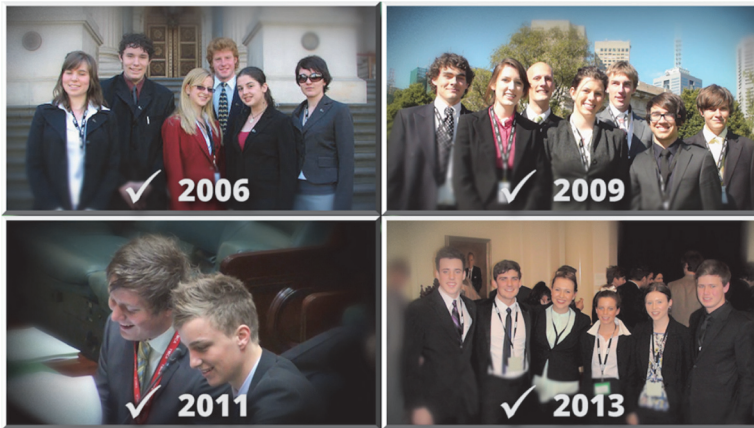


Figure 18: Victoria's Youth Parliament has successfully passed assisted dying legislation four times out of four in the past decade.

Source: DyingForChoice.com

When the youth of Victoria can develop, introduce, debate and successfully pass assisted dying legislation four times out of four, it's time for an adult legislature to do it once.

Summary of Australian public attitudes

In summary, extensive research into voter attitudes shows that:

1. An overwhelming majority of voters support assisted dying in restricted circumstances.
2. Australian opinion in favour of assisted dying choice has been in the majority for around half a century and remains at sustained high levels.
3. Community support spans age, gender, education, income, region, religious affiliation and voting intention.
4. Assisted dying law reform is of a higher *personal* significance to voters than a raft of other policy areas, many of which have already been 'dealt with' by the legislature.
5. Contrary to conventional political wisdom, the attitudes of assisted dying supporters is on average more deeply entrenched than those of opposers.
6. Overall, election candidates supporting assisted dying stand to gain a significant number votes, while opposers stand to lose a significant number of votes.

Voter support for assisted dying law reform is in the very great majority in all but the most religious, and translates to a net loss of votes for opposed election candidates.

Recommendation 3

That the Western Australia Parliament familiarise itself with the extensive evidence of overwhelming public support for assisted dying, and that voters are likely to punish, at a general election, MPs who vote against a Bill to legalise assisted dying.

Australian health professional opinion

AMA opposed stance indefensible

The Australian Medical Association (AMA) has been vocally opposed to assisted dying law reform, through its President, Dr Michael Gannon. The AMA conducted a survey of (only) its own members in 2015/16, culminating in its executive determining to retain the association's officially opposed stance to assisted dying despite deep flaws in both the survey — which had been pointed out to the executive prior to its policy determination (Francis 2016c) — and in its interpretation of results (Francis 2017a). For example, despite multiple methodology biases *against* assisted dying the survey found:

- Only half (50%) agreed with the AMA's policy opposed to assisted dying;
- 52% said assisted dying can form a legitimate part of medical care; and
- 60% said assisted dying should be provided by doctors if lawful.

Given these results, the Executive's decision to remain opposed to assisted dying is indefensible since it fails to represent the diversity of views amongst its members, and majority support for doctor provision if legal. More recently, Dr Gannon has been censured by the Victorian branch of the AMA for tasteless and insensitive remarks about assisted dying law reform (Davey & Alcorn 2017).

The AMA purports to represent all Australian doctors. However, with a claimed membership base of 31,000 of 111,166 registered doctors as at 30th June 2017 (Medical Board of Australia 2017) the great majority (72%) of doctors are *not* AMA members (Figure 19).

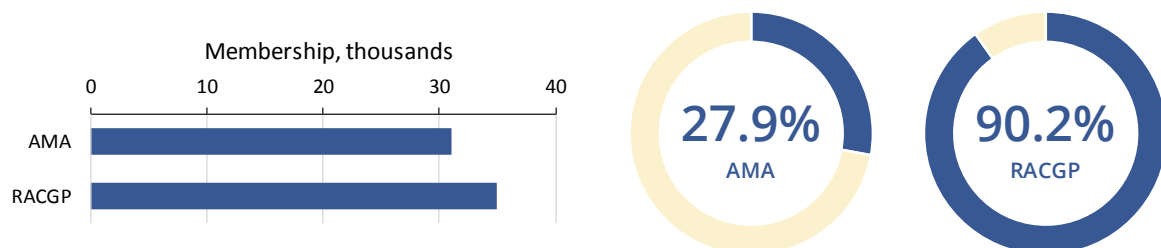


Figure 19: AMA and RACGP membership counts and proportions 2017

Sources: AMA personal communication, RACGP online data, Medical Board of Australia

RACGP supportive stance

In contrast, the Royal Australian College of GPs (RACGP) claims a larger membership amongst just this one speciality (35,000 members, Royal Australian College of GPs (2017a)) than the AMA has for all Australian doctors. RACGP membership represents 90% of Australian GPs (38,798 as at June 2017).

Recently, the RACGP has publicised its support for the legalisation of assisted dying with appropriate safeguards such as those in the Victorian *Voluntary Assisted Dying Bill 2017* (Royal Australian College of GPs 2017b).

Nurses & Midwives' Federation supportive stance

The Australian Nursing and Midwifery Federation has made clear its support for responsible assisted dying law reform (Australian Nursing & Midwifery Federation 2016).

Additionally, several ANMF branches have made their own statements of support, including the NSW (NSW Nurses & Midwives' Association 2017), Victorian (ANMF Victorian Branch 2017) and South Australian (Wills 2016) branches.

Australian Psychological Society supportive stance

The Australian Psychological Society has also released a discussion paper in response to the Victorian Parliament's *Voluntary Assisted Dying Bill 2017*, supporting assisted dying choice with appropriate safeguards (Australian Psychological Society 2017).

The AMA's hostile stance toward assisted dying law reform is indefensible given the results of its own survey finding much support; and the Royal Australian College of GPs, the Australian Nurses & Midwives' Federation, and the Australian Psychological society have all endorsed the reform.

Recommendation 4

That the Western Australia Parliament familiarise itself with the diversity of views amongst healthcare professionals, and that the AMA's opposition to assisted dying fails to reflect a majority of its own members' belief that assisted dying should be provided by doctors if legalised.

Part C: Opposing arguments critiqued

This section addresses Terms of Reference item 3.

Time to name up filibustering for what it is

Opponents of assisted dying law reform often claim that there is no 'rush' for reform. A typical example is Fr Brank Brennan, who says that "there is no hurry" and that it is "presently an academic issue" (Brennan 2011). Longitudinal research reported earlier in this submission clearly demonstrates otherwise: most voters want assisted dying law reform, and are prepared to punish MPs at election time in order to get it.

Opponents also argue that greater research effort into end-of-life experiences, motivation and vulnerability is necessary, and until then the 'question' of assisted dying ought to remain open.

However, we now have the advantage of many years' data gathered by experienced researchers, highlighting practice across jurisdictions where assisted dying is legal. The results are clear: controversial medical practices exist in all jurisdictions but they are not *caused* by assisted dying law reform. While practice of assisted dying has increased in lawful jurisdictions as the population become more aware of choice, the rate of controversial practices like non-voluntary euthanasia has in fact *decreased*. (More on this later.)

Suggesting the need for yet more research "*is a normative strategy, which is felicitous to the status quo [against law reform] and further medicalises the end of life, but which masquerades as a value-neutral assertion about needing more knowledge*" (Parker 2005).

Endless requests for more information is not value-neutral: it's filibustering.

The claim that we need yet more information and deliberation is a filibuster.

Hippocratic Oath fictions

Many of those opposed to assisted dying argue that it contravenes the Hippocratic Oath. However, the Hippocratic Oath is more than 2,300 years old. It is paternalistic (Miles 2009), contains no statements about compassion, integrity or honesty (Gruenbaum & Jotkowitz 2009), and scarcely concerns itself with patient welfare or outcomes but rather is a code for governing members of the profession (Robin & McCauley 1996). Further, it:

- Demands allegiance to ancient Greek gods;
- prohibits women from entering the medical profession;
- requires current doctors to train the following generation free of charge; and
- forbids surgery. (Edelstein 1943)

It is hardly surprising then that the Hippocratic Oath has been described as "steeped in sexism, secrecy, self-aggrandisement, and sorcery" (Robin & McCauley 1995). What is accepted as a normative and admirable code of practice in one era can appear quaint or outrageous in another (Meffert 2009).

Australian medical students do not take the Hippocratic Oath. Some medical schools adopt the Declaration of Geneva which has recently been revised (Parsa-Parsi 2017). However, neither the previous nor current versions of the Declaration outlaw or even mention assisted dying, despite

some, including the President of the Australian Medical Association, Dr Michael Gannon, claiming that it does (Gannon 2017). Nevertheless, the World Medical Association (responsible for the Declaration of Geneva) has separate documents containing statements opposed to assisted dying (World Medical Association 2013). Note that these policies were adopted by majority vote and fail to represent the true diversity of views amongst members.

Back to oaths: other institutions, like the University of NSW, have the medical class compose their own declaration, which in practice has contained no statements about euthanasia, abortion or other practices (McNeill & Downton 2002).

A thorough examination of oaths taken in USA medical schools found that only 18% of schools used an oath prohibiting assisted dying (Kao & Parsi 2004).

In any case, oaths are not the appropriate foundation for understanding medical philosophy (Jotterand 2005), and they cannot and do not guarantee morality (Sritharan et al. 2001). Are we suggesting that doctors who graduate from medical schools without an oath are less moral than graduates of schools with one—surely nothing but an ‘entertaining’ notion (Loudon 1994)?

Medical students do not take the Hippocratic Oath. Modern oaths, where taken at all, rarely contain statements prohibiting assisted dying.

‘First do no harm’ fails in the real world

The Committee will have received numerous submissions imploring it to reject assisted dying on the basis that doctors are obliged to ‘first do no harm’—the non-maleficence principle.

Firstly, the claim has little to do with the real world. Many medical interventions cause harm, for example surgery, chemotherapy, and even common pharmaceuticals. We conveniently call these outcomes ‘side-effects’, yet they are clearly and unequivocally ‘harms’.

It is therefore false and misleading to say that medicine can in practice “do no harm”. It does. Often.

Based on discussion with their doctor about potential benefits and harms, and their likelihood, a patient will judge and weigh the information in their own context, and decide whether to proceed with treatment or not.

There’s the crux: it is *the patient* who assesses the situation according to the information, their own context, and whether the options accord with their own deeply-held values, beliefs and world views. For example, a Jehovah’s Witness may decide to decline a simple life-saving blood transfusion, and that decision is honoured even though the direct and foreseeable consequence is death.

The principle is that it is the *patient*—not a medical association or academic philosopher—who decides what constitutes harm (or a *greater* harm) in his or her own context.

Overseas experience clearly shows that dying people don’t *want* to die, but find it a lesser harm than enduring. The Hon. Ken Smith asked Oregon doctor Peter Regan, who has helped a handful of patients to die under their Death With Dignity Act, why there wasn’t an avalanche of assisted deaths as predicted by critics of the law:

“I cannot imagine why they would [expect an avalanche] anywhere. It just turns out that people don’t want to die!”

By referring to their own beliefs and values and in the face of intolerable and unrelievable suffering, patients may decide that dying is a much lesser harm than the harms to be experienced by enduring. They may even believe that 'being dead' is not a harm at all.

Secondly, not only lay people, but medical 'experts' and associations (remember the 'authority' bias) opine that medicine's goal is to 'heal', not 'kill'. But it's wrong to suppose that medicine (or any other discipline for that matter) has *only one* simplistic purpose or goal.

Medicine has not one, but four major purposes (Hastings Center Report 1996):

1. The prevention of disease and injury and promotion and maintenance of health.
2. The relief of pain and suffering caused by maladies.
3. The care and cure of those with a malady, and the care of those who cannot be cured.
4. The avoidance of premature death and the pursuit of a peaceful death.

It is clear that purposes 2 and 4 are in conflict. Even purpose 4 alone has internal conflicts: the relief of pain and suffering and the pursuit of a peaceful death sometimes can only be achieved through a hastened death.

The arguments against doctors hastening a patient's death have been critiqued in detail and found to fail. "*Such a duty* [to not hasten death] *is now no more fundamental to the profession than a duty to relieve suffering, which may in some cases override it*" (Seay 2001).

'First do no harm' is superficial and unrealistic because medicine often does harm. Medicine also has goals that can come into conflict: assisted death as the only means to provide relief of suffering may on occasion take precedence over avoidance of a premature death.

Assisted dying is not about 'saving money'

The Committee will also have received submissions asserting that assisted dying must be rejected because its purpose or outcome is to save money.

This shabby imputation of rapacious self-interest fails at the first hurdle of logical examination. Healthcare institutions, and doctors, create jobs and earn income by servicing the medical needs of patients. *They can't do that when the patient has died.*

An equally shallow counter-imputation is that healthcare institutions and doctors over-service patients for the express purpose of generating income, accounting for opposition to assisted dying law reform.

Both arguments are unworthy and grotesque. We can note, however, that while the *purpose* of assisted dying is to provide choice to those who strongly need and want it and is nothing to do with money, allowing assisted dying choice does *not* exert *upward* pressure on the health budget.

In any case, potential savings would be very minor. Research in the USA has estimated that at both the individual patient level and the state healthcare budget level savings would be tiny—of the order of less than one tenth of one percent (Emanuel & Battin 1998).

Arguments about saving (or making) money are ill-informed and insulting to doctors and institutions. While assisted dying law reform does not exert upward pressure on health budgets, estimated savings are negligible.

Assisted dying is consistent with the right to life

The Committee will have received submissions arguing that assisted dying is incompatible with the right to life. The claim is unfounded because it confuses a right with an obligation. An example will help to illustrate.

In March 1912, Captains Robert Scott and Lawrence Oates (and others) were returning from the South Pole when bad weather overcame them. Running out of supplies they were aware they were going to die (rather like terminally ill patients). Scott records in his diary that Oates, leaving their tent for the blizzard outside, said “I am just going outside and may be some time”.

At all times Oates had a *right* to life. But he did not have an *obligation*. As a terminally ill patient might, the thought of a long and lingering death would have been a greater harm to him than would a much shorter one.

A right is not an obligation. The *right* to life remains even when an individual chooses an assisted death.

Palliative care availability improves

Assisted dying opponents often invoke a popular but false ‘competition’ between palliative care and assisted dying. In jurisdictions where assisted dying has been legalised, palliative care availability has improved — including increases in funding — rather than deteriorated.

Improvements to palliative care were deliberate facets of assisted dying law reform in both the Netherlands and Belgium, with increased funding in both countries at the time assisted dying was legalised.

Oregon and Washington too have seen strengthening of palliative care, as two of only eight USA states to be awarded an “A” grade for palliative care (Morrison et al. 2011; Tolle & Teno 2017).

Claims that assisted dying is in ‘competition with’ or ‘damages’ palliative care practice are contradicted by the evidence.

Trust in doctors remains high

Another common claim amongst assisted dying opponents, particularly doctors, is that legalising assisted dying would erode the trust that the community holds for the medical profession.

This assumption is at odds with the facts. People’s trust in doctors is very high amongst OECD countries *with* assisted dying laws (Saarinen, Räsänen & Kouvo 2016). Indeed, public trust in doctors amongst Swiss, Dutch, and Belgian citizens are three of the top five OECD results, and are

significantly higher than Australians' trust in doctors (Figure 20),³ showing that the AMA still has some work to do in building trust.

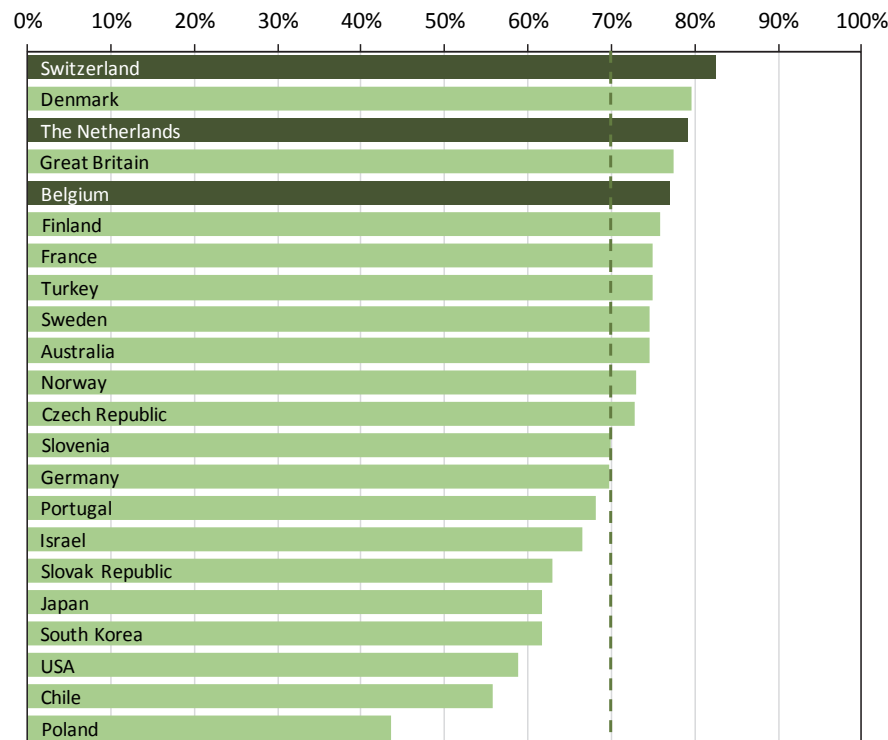


Figure 20: General trust in doctors across 22 OECD countries
 Source: Saarinen, Räsänen and Kouvo (2016). Note: Dashed line is mean of all results.

In regard to *changes* of public trust in doctors specifically if assisted dying were legalised, several overseas studies provide valuable insights. A 1996 USA study found that amongst the public, 91% would trust participating doctors while only 86% would trust non-participating doctors. A mere 5–8% of the public said they would 'likely' change doctors if theirs participated, while *none* said they would 'definitely' change doctors (Graber et al. 1996).

A 2005 USA study (Hall, Trachtenberg & Dugan 2005) found a majority (58%) of the public thought doctors providing assisted dying would increase trust in doctors, with just 20% believing trust would be diminished; an 'improved trust' ratio of almost three to one (Figure 21). A 2009 Swedish study (Lindblad, Löfmark & Lynöe 2009), where public attitudes towards 'physician assisted suicide' (73% in favour, 15% undecided, 12% opposed) are also similar to those in Australia, found that legalisation of assisted dying would increase trust amongst 38%, not influence trust at all among 45%, and would decrease trust among 17% of the public, a ratio of more than two to one towards increased trust. Of the 17% opposed to law reform, 75% indicated that their trust in doctors would decrease.

Additionally, a 2015 UK survey, where public attitudes toward assisted dying were also similar, found that a much larger proportion of the public (38%) thought that legalising assisted dying would increase trust in doctors rather than decrease it (12%), an improved trust ratio of more than three to one (Populus 2015).

³ These results were obtained using consistent methodology across the OECD countries. There is an IPSOS poll in Australian only showing 90% public trust in doctors, but rather than independent and absolute, the result is *relative* to other professions including clergy, business leaders, union officials and politicians (Medew & Spooner 2016).

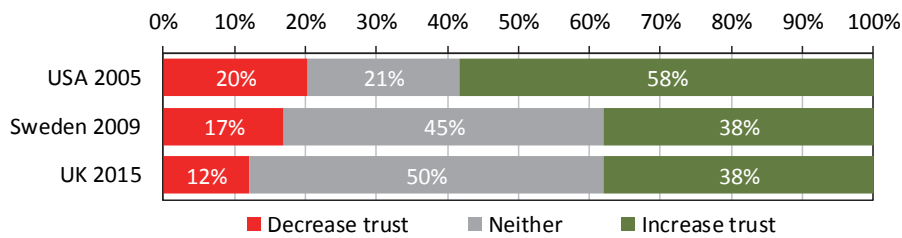


Figure 21: Public attitudes toward how legalisation of assisted dying would affect patient trust in doctors
Sources: Hall, Trachtenberg and Dugan (2005), Lindblad, Löfmark and Lynöe (2009), Populus (2015)

In 2015/6, the AMA asked its members to agree with the statement, “Doctor-provided euthanasia would damage patient trust” (Australian Medical Association 2016). However, a majority (53%) expressly disagreed with the statement (Figure 22), while fewer than a third agreed.

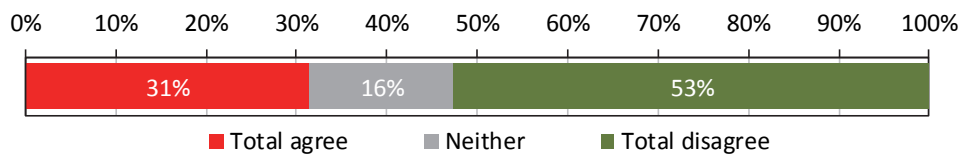



Figure 22: ‘Doctor-provided euthanasia would damage patient trust’
Source: Australian Medical Association (2016)

Yet despite all the readily-available evidence, some doctors, including AMA President Dr Michael Gannon, claim that legalisation of assisted dying would only damage trust in doctors.

 **@amapresident 11 Nov 2016:** Doctors maintain this Trust with everyday care for patients, by upholding #DeclarationOfGeneva @medwma @juliamedew @Rania_Spooner #ethics

Trust in doctors in lawful assisted dying jurisdictions is high,
and trust in doctors would increase if assisted dying were legalised.

Ample evidence against ‘slippery slope’ theories

Opponents of assisted dying law reform often warn of dire consequences: that ‘vulnerable’ patients would be ‘at risk’ from pressure to choose the option. There are three broad reasons why these arguments fail: rhetorical sham, unsupported by overseas evidence, or unsupported by domestic evidence.

Failure 1: Rhetorical sham

“The vulnerable will be at risk if we legalise assisted dying!”

Various forms of this argument are advanced not only by lobbyists, commentators, journalists and politicians, but even by judges and professional medical bodies (see examples below).

But the statements are silly and nonsensical flapdoodle because they use *circular rhetoric* dressed up as a profound or self-evidential truth to fabricate a case for or against change (Figure 23).

The fabrication is to present ‘the vulnerable’ and people ‘at risk’ as different groups. They aren’t. The Oxford English dictionary *defines* ‘the vulnerable’ as “at risk”, and Merriam-Webster agrees: “open to harm”.



Figure 23: The 'vulnerable' are not *sometimes* at risk, they are by definition *always* at risk

Therefore it's a *circular sham* to argue that a group *becomes* itself on the basis of some arbitrary external change. We could equally say (Figure 24):



"The vulnerable will be at risk if we wear yellow socks on Wednesdays."

Figure 24: The circular sham can be attached to anything with which we disagree

Indeed, the argument can be used for any socio-political purpose: "Unless we prohibit religion the vulnerable will be at risk of religious extremism leading to terrorism."

Examples:

1. *Magazine article:* Bill Muehlenberg (2008), Quadrant Online, 3-Sep, <http://quadrant.org.au/opinion/bill-muehlenberg/2008/09/some-objections-to-legalised-euthanasia/> (viewed 28-May-2014), "**The most vulnerable will be at risk ... with legalised euthanasia**".
2. *Anti-euthanasia campaign website:* Alex Schadenberg (2013), **Assisted dying law would bring risks for the vulnerable**, <http://alexschadenberg.blogspot.com.au/2013/11/assisted-dying-law-would-bring-risks.html> (viewed 28-May-2014).
3. *Legislator's speech in Parliament:* Rev. Hon. Dr Gordon Moyes (2003), Speech by the Rev. Hon. Dr Gordon Moyes AC, MLC in the NSW Legislative Council Chamber on The Voluntary Euthanasia Trial (Referendum) Bill 2003, "**The most vulnerable will be at risk ... [from] voluntary euthanasia**".
4. *Professional medical body statement:* British Medical Association (2014), What is current BMA policy on assisted dying?, <http://bma.org.uk/practical-support-at-work/ethics/bma-policy-assisted-dying> (viewed 28-May-2014), "**Permitting assisted dying for some could put vulnerable people at risk**".
5. *Supreme Court (Canada) determination:* Rodriguez v. British Columbia (Attorney General), [1993] 3 SCR 519, "... **persons who may be vulnerable to the influence of others ... may find themselves at risk at the hand of others ... [in the intentional termination of life]**", p. 558.

When it comes to self-proving rhetoric, no case is made when a circle is laid.

Failure 2: Unsupported by overseas evidence

An international, peer-reviewed study into hypothetical “vulnerable” groups has shown no evidence of heightened risk for the elderly, women, the uninsured, the lesser educated, the poor, the physically disabled, the chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations, whether under the law or outside it (Battin et al. 2007).

Battin’s research has been criticized by Finlay and George (2011), a critique widely quoted by assisted dying opponents. However, Finlay and George’s critique is flawed and unpersuasive. For example, while they continue to assert that the elderly *are* ‘vulnerable’ in Oregon, empirical data shows otherwise. Oregon Health Authority statistics for assisted deaths (Oregon Health Authority 2015) show that at the time of Finlay and George’s criticisms, use of the Death With Dignity Act peaks among 55-64 year-olds. If ‘elderliness’ were a vulnerability, the rate of use of the Act would trend upwards amongst 65-74, 75-84 and 85+ year olds. However, the rates for the older age groups in fact trend downwards (Figure 25).

The empirical evidence does *not* support Finlay and George’s continued contention of a slippery slope amongst the elderly: most people using assisted dying laws do so due to untreatable and intolerable suffering from advanced cancer — not because they are a certain age or ‘vulnerable.’

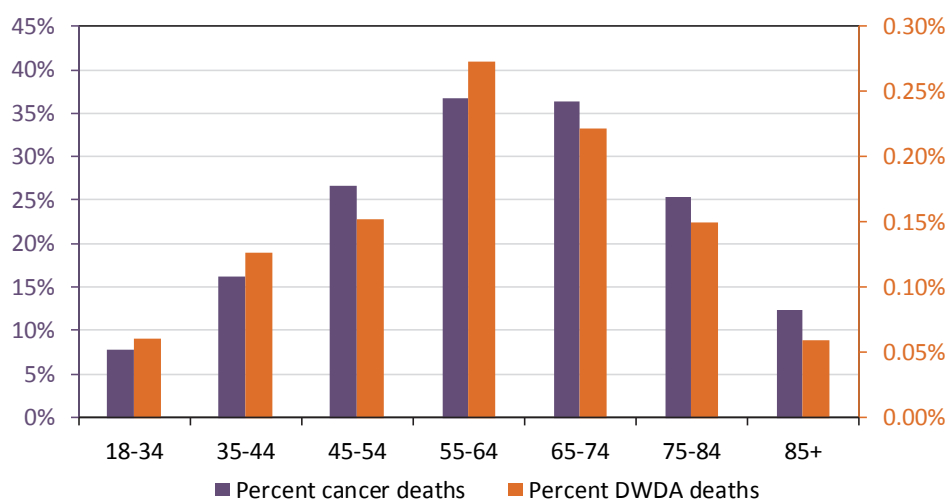


Figure 25: Cancer and assisted deaths as a percent of total deaths in Oregon 1998-2010 by age group
Sources: CDC Wonder (2017), Oregon Health Authority (2015). DWDA = Death With Dignity Act. Note: Chart produced to data available at time of Finlay and George claim. The data to 2015 (most recent available) is similar.

The situation in Oregon is consistent with Belgian data, which shows a similar profile for assisted dying *and* for cancer deaths in that country (Figure 26). This is hardly surprising since the great majority of people who use assisted dying laws have advanced cancer.

While empirical data can be difficult to find, matching data for assisted dying age cohorts for cancer death rates in Belgium was found for the years 2012–13 (Figure 26).⁴

⁴ The Belgian euthanasia commission only commenced reporting age cohorts in 10-year intervals in its 2012–13 report; and 2012–13 are the most recent two years for which government data for cancer deaths is available. The Netherlands euthanasia commission does not report age cohort data.

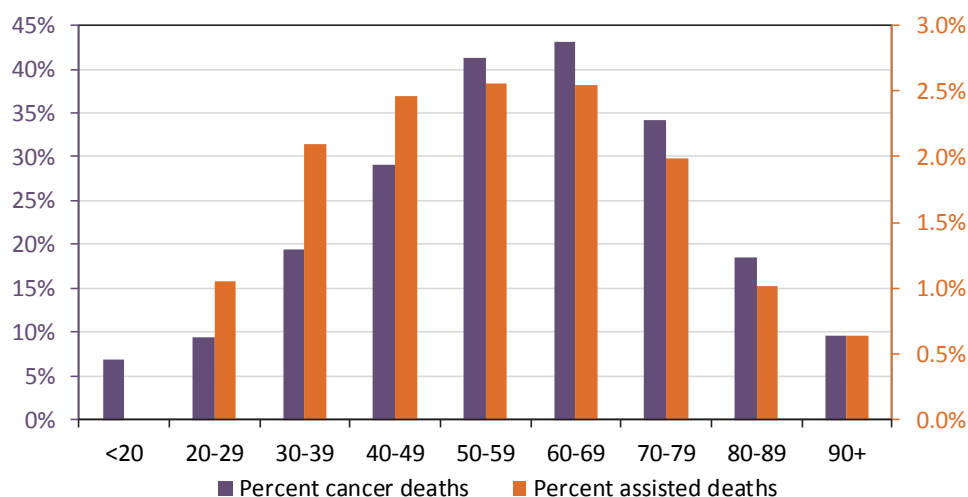


Figure 26: Cancer and assisted deaths as a percent of total deaths in Belgium 2012–13 by age group
 Sources: Official euthanasia commission reports, government mortality data by illness. Note: 2012-13 are the years for which this granular data are available for both variables.

Like Oregon’s, the Belgian assisted dying age cohort profile is similar to the total cancer deaths profile, and skewed slightly towards *younger* ages. Amongst the elderly the odds of assisted dying is decreased rather than elevated. The younger-age skew is possibly the result of lower rates of religion and higher acceptance of assisted dying amongst younger individuals.

The data is at odds with ‘vulnerable’ hypotheses: females and the elderly appear to be underrepresented, not overrepresented, in assisted dying cases.

As Harvard University Professor of Psychology Steven Pinker says:

“For [slippery slope] hypotheses to justify restrictive laws, they need empirical support. In one’s imagination, anything can lead to anything else ... In a free society one cannot empower the government to outlaw any behaviour that offends someone just because the offender can pull a hypothetical future injury out of the air.” (Pinker 2008)

Empirical evidence is at odds with the theory that the elderly, the uninsured, or other groups are ‘vulnerable’ to assisted dying laws.

Failure 3: Unsupported by domestic evidence

Evidence against the ‘slippery slope’ theory is also available closer to home. There are ready and useful parallels for end-of-life decision making in Victoria (and elsewhere) that provide powerful insights.

For the most part, Finlay and George (2011) argue that ‘the vulnerable’ doesn’t mean the poor, the uninsured, the lesser educated, the physically disabled, the chronically ill or other groups. They refer instead to ‘emotional vulnerability’ and ‘personality type’ as the drivers of vulnerability, and that there “exist[s] across the spectrum of society ... perceived pressures from others or from within themselves, or under the influence of treatable or transient depression”.

If these factors were indeed the drivers of ‘vulnerability’, then they must also apply equally and identically to *all* contexts in which a patient may choose death (or other perceived harms) over other

alternatives. **The principle would apply *equally and exactly* to the refusal of life-saving medical treatment** (Dworkin, Frey & Bok 1998, p. 66ff).

Refusal of life-saving medical treatment

In Victoria, patients have the right to refuse any unwanted medical treatment, even if the treatment is life-saving. For the refusal to be valid and binding, the *Medical Treatment Act 1988 (Vic)*⁵ not only requires the patient to complete and sign a certificate, but be informed about diagnosis, prognosis and available treatments, and mental capacity assessed by one doctor. Thus, there are just three safeguards in relation to refusing life-saving medical treatment. But even those don't apply in all cases as they relate only to refusals given in writing. If the refusal is made verbally there are *no* statutory safeguards at all.

In contrast, overseas laws permitting assisted dying — with the notable exception of Switzerland — contain a significant number of safeguards. Victoria's *Voluntary Assisted Dying Bill 2017* has no fewer than 68.

Victoria's *Medical Treatment Act* provides a penalty, in Section 5F, for inappropriate pressure to obtain a refusal of treatment certificate. If 'vulnerable' patients were susceptible to the subtle pressure of greedy relatives and others to choose to die, then there would according to slippery slope theory be an avalanche of inappropriate persuasion and deaths through refusal of life-saving medical treatment.

However, in the almost three decades of the *Medical Treatment Act*, Victoria Police confirm that there have been *no* prosecutions for breaching Section 5F of the Act. Not one.

So much for that slippery slope theory.

Voluntary refusal of food and fluids

A patient may also choose to die by voluntary refusal of food and fluids (VRFF). The option is legal in Australia, and death is likely to occur within around 14 days. The supposed 'vulnerability' argument of inappropriate persuasion also applies to VRFF in precisely the same way as it does to refusal of treatment and to assisted dying.

VRFF was promoted by Dr Bill Sylvester, Director of the Respecting Patient Choices program at the Austin Hospital, in a public debate at Melbourne Town Hall late in 2012 (ABC News 24 2012). Dr Sylvester first argued that assisted dying must be opposed because patients could be persuaded to take it, and doctors (including himself) are good at persuading patients to choose things. He then argued law reform was unnecessary because VRFF (dehydrating yourself to death) was a good option. His suggestion met a hostile reception from the audience, requiring intervention by moderator Simon Longstaff.⁶

The incoherence of the argument was obvious: if a doctor was good at persuading a 'vulnerable' patient to choose assisted dying (currently illegal), then he or she would be equally adept at persuading a patient to refuse life-saving medical treatment (currently legal in Victoria for nearly three decades with no prosecutions) or to refuse food and fluids until death (currently legal).

There's more. Victoria's *Medical Treatment Act* also provides for a person to appoint a substitute decision maker ('agent') to assist decision making in the event that the person is no longer able to

⁵ The *Medical Treatment Act 1998* will be extinguished in March 2018 when a more advanced replacement, the *Medical Treatment Planning and Decisions Act 2016*, comes into force.

⁶ Later, online, 'Paul Russell' posted the comment: "*Was Bill deliberately trying to make Al Qaeda look compassionate or was that simply incidental?*"

participate. The agent has authority to accept and decline any and all medical treatments (provided the decisions are in accordance with the person’s wishes), and that can include refusing life-saving medical treatment.

The person can—and usually does—appoint a trusted family member to the role of agent. The agent is permitted under the Act to be a beneficiary of the patient’s estate... at the same time as having the power, when the person can no longer decide, to refuse life-saving treatment.

Why isn’t this a recipe for elder abuse, as opponents of assisted dying claim? While elder abuse is a real and significant community issue, the answer is simple. By placing the appointment of an agent and refusal of treatment (or assisted dying) under the spotlight, by ensuring the patient is well informed, by assessing the patient’s mental capacity, by ascertaining the real appetite of the patient for the choice, and the signing and witnessing of documents, the process *destroys the cloak of privacy and secrecy necessary for the commission of elder abuse*.

Three identical contexts, only one of which remains illegal

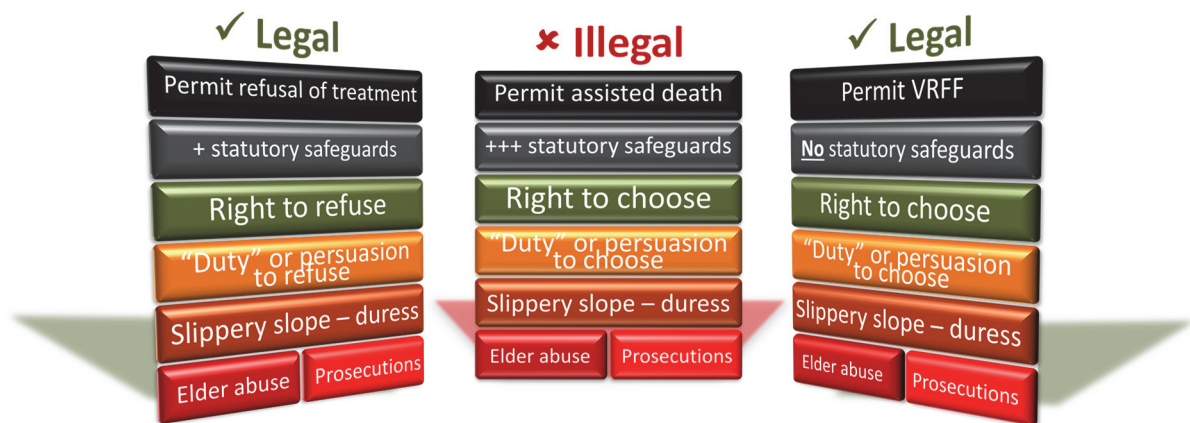


Figure 27: Three identical theoretical ‘vulnerable’ slippery slopes, two of which are currently legal
 Note: VRFF = Voluntary Refusal of Food and Fluids

It is ethically and logically indefensible to argue that two of these models (refusal of life-saving medical treatment and VRFF) are acceptable and sound in the context of ‘vulnerability’, while criticising and rejecting the third one (assisted dying) with considerably more safeguards (Figure 27).

It is incoherent and indefensible to support choice in two contexts but to oppose it for an identical third context.

Opposing world views can be concurrently accommodated

Those opposed to assisted dying characterise it as ‘killing’, while those who support choice characterise it as a ‘compassionate choice’. Who is right?

Since these opposing stances are founded on underlying personal beliefs and moral principles, rather than objective evidence or ‘proof’, the answer is of course that they are *both* right—to their own adherents.

Nevertheless, an observation about ‘killing’ is warranted.

If it is 'killing' to assist a patient whose rational and dearest wish is to die peacefully in order to escape the torture of their terminal illness, then operating on a patient is "stabbing and slashing." This is no trivial comparison. Stabbing and slashing is technically what a doctor does in surgery.

The comparison provides a crystal-clear example of the evolution of social attitudes. Surgery was banned by the Hippocratic Oath — the Oath that assisted dying opponents *selectively* state bans assisted dying — due to exceptionally poor outcomes; to infection and other complications or harms. For many centuries, surgery in Western society was deemed low-order stabbing and slashing. It was performed in the middle ages by *barbers*, accounting for the traditional red and white poles (cascading blood) that we still see outside barber shops today.

While assisted dying opponents believe the concept of deliberately hastening death offensive, supporters believe that referring to it as 'killing' is as offensive as referring to surgery as 'stabbing and slashing'. In both cases the negative language imputes malicious motives, whereas those participating have beneficent motives.

These opposing world views are irreconcilable, but a solution is readily at hand: choice.

Legislation that allows those who seek or are willing to support a hastened death to do so, at the same time as those opposed may elect not to participate, permits both world views to co-exist.

Recommendation 5:

That the Western Australia Parliament takes care to inform itself about arguments against assisted dying which are illegitimate, incoherent, unsupported or indeed contradicted by empirical evidence, or amount to filibustering.

Part D: Correcting misinformation about lawful jurisdictions

This section addresses Terms of Reference item 3.

Misinformed claims by opponents of assisted dying law reform about jurisdictions where it is lawful are imaginative, highly varied, frequently stated and widely broadcast (remember the repetition bias). Many varieties will have appeared in numerous submissions to this inquiry.

This report corrects selected common false claims about lawful jurisdictions. It is illustrative rather than exhaustive.

Dr Els Borst remains proud of euthanasia law reform

Dr Els Borst was the Minister for Health who introduced the Euthanasia Bill to the Dutch parliament, which was passed in 2001 and came into effect in 2002.

In an opinion piece published on 28th November 2009 in Dutch newspaper NRC, it was said that Dr Borst regretted this reform. Within three days, on 1st December, Dr Borst published an unambiguous rebuttal of the opinion, stating that it was untrue she regretted the law and its implementation.

However, in a public lecture delivered by Catholic anti-euthanasia campaigner Professor Margaret Somerville at the University of Tasmania on 30 Jun 2011, Somerville said:

"The Minister who was responsible for shepherding through the legislation that legalised euthanasia in the Netherlands admitted publicly that doing so had been a serious mistake." (Somerville 2011)



Professor Margaret Somerville wrongly claims that Minister Els Borst regrets her decision.

Somerville made the statement categorically, yet when challenged by a member of the audience that it was untrue, she then equivocated, made further unsubstantiated assertions and then changed the subject.

In an on-camera interview I conducted with Dr Borst in Utrecht in 2012, I asked her what her current attitude towards the law was. She confirmed without hesitation:

"I am still very happy with it. I think we did the right thing there, also in the way we formulated it."

And in regard to Somerville's claim:

"I'd like to meet this ... Margaret Somerville... but perhaps she wouldn't listen anyway."



Dr Els Borst confirms she remains happy with the Dutch euthanasia law.

Despite Dr Borst's clarity in confirming she does not regret the law reform, the assertion that she does continues to be repeated. It appears, for example, in the Australian Family Association submission (number 613) to the Victorian End-of-Life Choices inquiry. It has also been used invalidly by legislators to oppose legislation being debated in Parliament, for example as the Hon. Dennis Hood did in a November 2010 debate in South Australia (Hood 2010).

A brief video of Borst and Somerville's statements is available at DyingForChoice.com (Francis 2017e).

It is false to claim that Dr Els Borst regrets the Dutch euthanasia law reform. She expressly confirmed that she remains very happy with it.

Dutch elderly happy with nursing homes

In my interview with Dr Els Borst, she recounted an event from the 1990s in which she and the Dutch Foreign Minister visited the Vatican and demanded they stop publishing lies about elderly Dutch being fearful of going into nursing homes, believing they would be killed by their doctors in the middle of the night. Furious, the two Ministers advised the Vatican that the Dutch Ambassador would be withdrawn from the Vatican, never to return, unless they stopped publishing such lies. The Vatican did not publish such statements again.

However, in the same public address as above, Professor Margaret Somerville said this:

"Old Dutch citizens are seeking admission to nursing homes and hospitals in Germany, which has a strict prohibition against Euthanasia because of its Nazi past, and they're too frightened to go into nursing homes or hospitals in the Netherlands." (Somerville 2011)

There is no evidence to support this claim in the research literature, although it is popular scuttlebutt on the Internet. I put the recording of Somerville's claim to a number of people in the Netherlands. All dismissed it. Professor Heleen Dupuis, Dutch Senator, doctor and a Professor of ethics put it politely though still with some amused exasperation:

"OK, stupid. It's simply not true. And as a professor of ethics I like to be honest... it is absolute nonsense."

Retired Dutch MP, Professor Eric Jurgens, agreed:

"I think that, in Dutch public opinion, such commentaries are regarded as ridiculous."

A brief video of Borst, Somerville and Dupuis' statements is available at DyingForChoice.com (Francis 2017d).

Elderly Dutch are not 'frightened' to go into nursing homes and hospitals in the Netherlands and are satisfied with them, as most citizens around the world are with their own.



Dutch Senator and medical ethicist Prof. Heleen Dupuis finds Somerville's argument more than faintly ridiculous.

Non-voluntary euthanasia rates fall, not rise

Adding to our stock of empirical evidence, detailed medical research has been conducted around the world, including longitudinal research in the two countries with the longest-running voluntary euthanasia laws: the Netherlands and Belgium.

Voluntary euthanasia has been lawful in the Netherlands arguably since the early 1970s (Postma case 1973), but certainly by the mid-1980s (Schoonheim case 1984) when prosecutorial authorities declared that doctors would not be pursued for assisting a patient's death in certain circumstances and the Royal Dutch Medical Association (KNMG) issued its first guidelines for doctors. In the early 1990s, revised requirements were published. In 2002, the voluntary euthanasia Act came into effect, recognising both voluntary euthanasia and physician-assisted dying.

In Belgium, assisted dying was illegal in all forms prior to 2002, the year their voluntary euthanasia Act came into effect. While the Act formally recognises voluntary euthanasia, it is also taken to recognise the practice of physician-assisted dying. The Belgian and Dutch Acts make similar though not identical provisions for qualification criteria and procedural safeguards.

In addition, Switzerland has had an assisted suicide law in effect since 1942. It has only *one* criterion, in Article 115 of the Criminal Code: that assistance in suicide may only be provided for non-selfish motives. That alone exempts a person from criminal liability for assisting the suicide of another. There are *no* qualification or procedural criteria as in the Belgian or Dutch Acts.

How has legalisation of assisted dying in these countries affected medical practices, particularly controversial ones like non-voluntary euthanasia (NVE) — hastening a patient's death without a current explicit request from the patient?

NVE is controversial for a number of reasons. There are disagreements about what it encompasses and how it arises, and whether it includes or excludes the doctrine of the double effect (itself not uncontroversial amongst ethicists) if the patient hasn't been consulted. Note that a mentally incompetent patient cannot discuss their end-of-life decisions and so substitute decision making is necessary. In contrast, the Dutch and Belgian Acts provide for assisted dying decisions only by mentally competent patients: the Dutch, in advance. For simplicity, we will accept that at least some forms of NVE practice are 'problematic' and it is desirable that they occur at a lower rather than higher incidence.

A study by van der Heide et al. (2003) provides a snapshot of NVE rates prior to the Dutch and Belgian euthanasia Acts coming into effect (Figure 28). This major international collaborative study used the same methodology across seven countries.

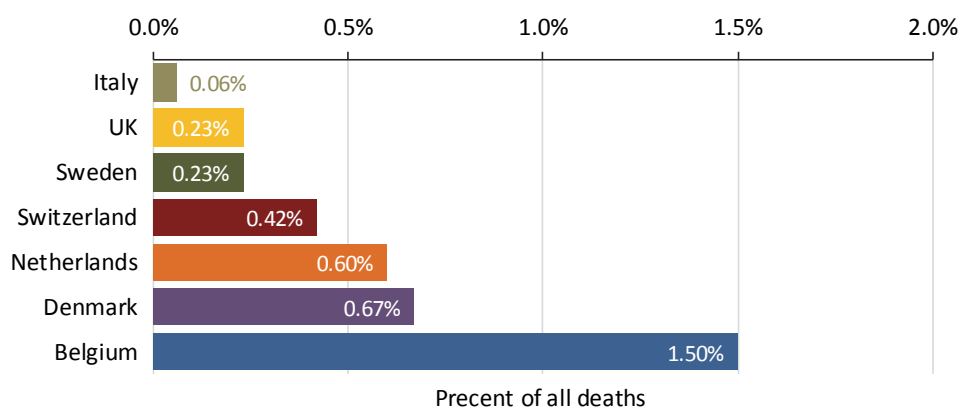


Figure 28: Non-voluntary euthanasia rates in seven countries in late 2001

Source: van der Heide et al (2003)

It's important to note that at the time of van der Heide's research:

- The Netherlands had allowed voluntary euthanasia and physician-assisted dying via regulation (not statute) for around 20 years.
- Switzerland allowed assisted suicide since 1942.
- In all other countries, assisted dying in any form was illegal.

The important information we can glean from this research is that:

- Switzerland's NVE rate is average, despite it having the world's oldest assisted suicide law, and which has just a single requirement (non-selfish motive) for legality.
- The Dutch NVE rate is not especially high, despite euthanasia being lawful via regulation for some twenty years.
- Denmark's NVE rate is higher than either Switzerland or the Netherlands, despite not having an assisted dying law.
- Belgium's NVE rate is significantly higher than the other countries, but cannot be the result of an assisted dying law because such a law did not exist at the time.
- Italy's NVE rate is especially low, much lower than the UK—the world's gold standard for palliative care. It is possible that severe patient symptoms in Italy are inadequately palliated, though this interpretation would need to be tested through further research.

Prior to the Dutch and Belgian Euthanasia Acts, differences in NVE rates are clearly the result of different cultures of medical practice, because they can't be attributed to assisted dying Acts that didn't exist at the time.

But does a country's underlying culture of medical practice *mask* unwanted assisted dying law effects? To answer that 'slippery slope' question, we need to establish that the rate of NVE went *up* after assisted dying entered the statute books.

Indeed, proposers of the VE-to-NVE 'slippery slope' theory would need to articulate a robust mechanism through which such an effect would supposedly occur. It is untenable to argue that a practice—deliberately hastening a patient's death without a direct and explicit request from the patient—does *not* occur while it is illegal (prior to assisted dying law), but *will* occur while it is (still) illegal (after an assisted dying law).

Several primary research studies using similar methodologies provide insights into what happened to NVE rates after law reform (Bilsen et al. 2009; Chambaere et al. 2015; Onwuteaka-Philipsen et al. 2012; Seale 2009a; van der Heide, van Delden & Onwuteaka-Philipsen 2017).

Did the rate of NVE for either country go *up* after assisted dying was enshrined in statute, according to 'slippery slope' theory? No. In Belgium, the rate went *down* significantly. In the Netherlands, the rate also went *down* significantly, and is now around the same rate as in the UK, the world's gold standard of palliative care practice (Figure 29).

Despite the clear empirical evidence, many submissions to the Victorian end-of-life choices inquiry made either vague or particular claims of threatening 'slippery slopes' from voluntary euthanasia (VE) to NVE as a result of assisted dying laws. These submissions come not only from individuals who may not know better, but also from institutions (remember the 'authorities' bias) such as the Knights of the Southern Cross Victoria (submission 647).⁷

⁷ The Knights of the Southern Cross of Victoria submission demonstrates limited understanding of scientific evidence and the subject matter. It incorrectly refers to *non*-voluntary euthanasia as *in*voluntary euthanasia.

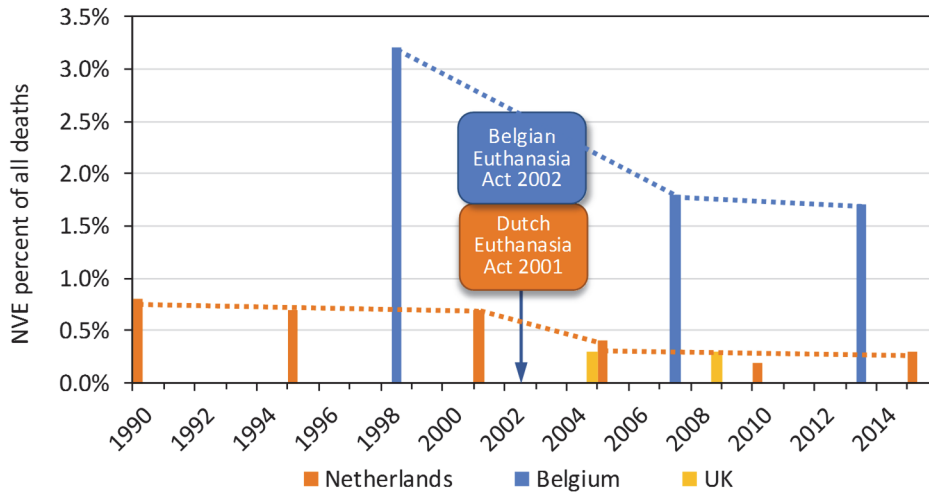


Figure 29: Longitudinal rates of non-voluntary euthanasia before and after assisted dying law reform
 Sources: Bilsen et al. (2009); Chambaere et al. (2015); Onwuteaka-Philipsen et al. (2012); Seale (2009a); van der Heide, van Delden and Onwuteaka-Philipsen (2017). Note: The Dutch 2005, 2010 and 2015 NVE rates are not statistically different from each other, but are highly significantly lower than the earlier rates.

A brief video outlining how Professor Margaret Somerville misrepresents the case is available at DyingForChoice.com (Francis 2017f).

Further detailed evidence explaining assisted dying practice in the European low countries can be found in my recent Whitepaper “Assisted dying practice in Benelux” (Francis 2016a).

Research clearly shows that NVE has dropped and stayed lower after statutory legalisation of assisted dying.

It refers to a series of data about NVE in the Netherlands but fails to articulate that the rate across the series went *down* rather than up. It refers to research data that is ten or fifteen years old, when much more recent data is readily available.

No suicide contagion

Opponents of assisted dying often claim that there is “suicide contagion” from assisted dying laws to the general suicide rate. The claim is contradicted by evidence from major jurisdictions where assisted dying is lawful.

Not in Oregon

Figure 30 shows official Oregon government census data on suicides in that state. The chart includes data available through the Oregon government’s web portal until 2010 (Oregon Health Authority 2012) in order to match statements made by assisted dying opponents. Part-way through the available data period, Oregon’s Death With Dignity Act has come into effect (1997). There is a small drop in the average rate of suicides since 1997.

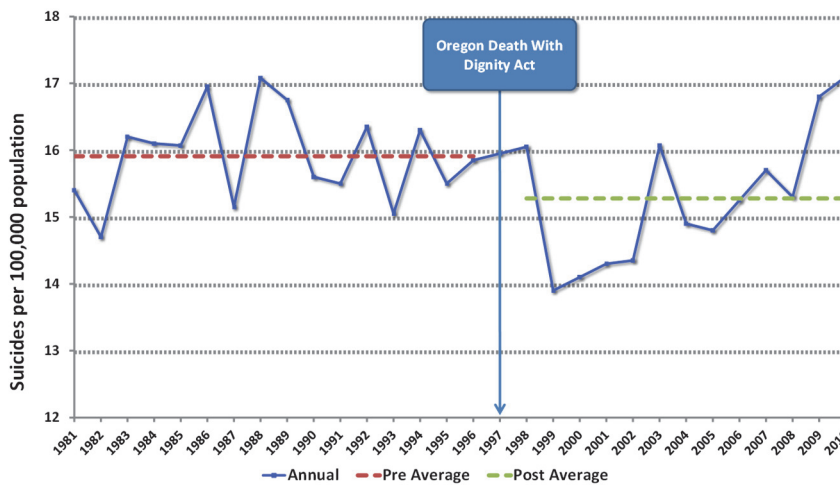


Figure 30: The suicide rate in Oregon between 1981 and 2010
Source: Oregon Health Authority 2012

While factors leading to suicide are often complex and multi-factored, it is well-recognised that a key driver of suicide rates is the state of the economy, unemployment in particular. Figure 31 adds the available USA Bureau of Labor Statistics for Oregon (Bureau of Labor Statistics (USA) 2014).

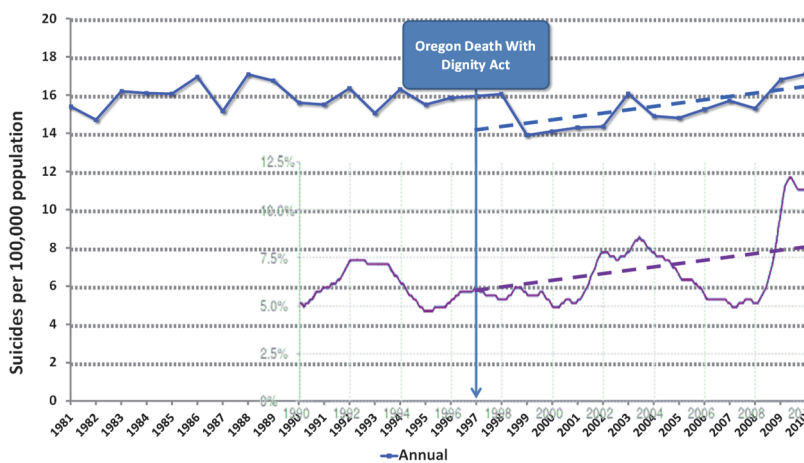


Figure 31: Oregon suicide and unemployment rates
Sources: Oregon Health Authority 2012, Bureau of Labor Statistics 2014. Note: unemployment data is purple

The official data confirms a strong relationship between unemployment and the overall suicide rate.

Yet Mr Alex Schadenberg of the Euthanasia Prevention Coalition (EPC) in Canada has published on his blog multiple opinion pieces arguing a causal connection between Oregon’s Dying With Dignity Act and the general suicide rate. Indeed, in one he wrote:

“Oregon’s overall suicide rate ... has been increasing significantly since 2000. Just three years prior, in 1997, Oregon legalised physician-assisted suicide. Suicide has thus increased, not decreased with the legalisation of physician-assisted suicide.” (Schadenberg 2013a)

Notice that Mr Schadenberg refers only to data *since 2000*. If we look at the official data as from this date, illustrated in Figure 32 and what it *implies*, one could be forgiven for accepting that suicide contagion is a result of Oregon’s Dying With Dignity Act. But the data is cherry-picked to support that argument, while the full data provides contrary evidence.

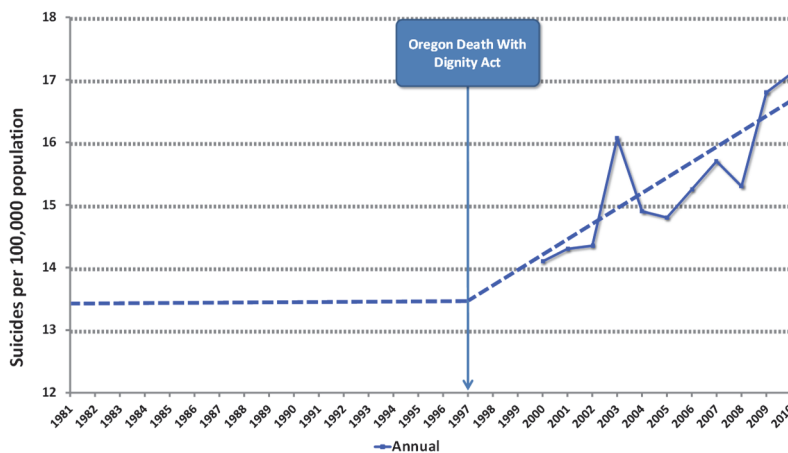


Figure 32: Alex Schadenberg refers only to a sub-set of the data that appears to confirm his theory
Source: Oregon Health Authority 2012

Domestically, Mr Paul Russell who runs the Australian Family Association’s anti-assisted-dying blog “HOPE” and is second in charge to Mr Schadenberg at EPC, also wrote:

“In Oregon following the introduction of doctor-assisted suicide, suicide by other methods went up and not down as predicted. This is consistent with suicide contagion or clusters.”
(Russell 2011)

I have challenged Mr Russell publicly on several occasions about this false claim, including in a video sent to all South Australian MPs in 2013. The article no longer appears on his blog, but now HOPE refers to other web pages that continue to make this false claim:

- [Assisted suicide: Is there a suicide contagion effect?](#) (in which Margaret Dore, an American attorney, argues only in the affirmative)
- [Suicide – contagion amongst the elderly?](#) (in which Paul Russell argues for the affirmative)
- [Canadian study proves that “suicide contagion” exists – more work needs to be done](#) (in which Paul Russell tries to argue that the research paper establishes the basis for something that it doesn’t: a contagion link from *assisted dying* to schoolchild suicide)

Potential ‘authority’ bias

False claims are not limited to lay observers and personal blogs. For example, well-known Oregon anti-assisted dying campaigners Dr William Toffler and Dr Kenneth Stevens published in the *British Medical Journal* the opinion that:

“Oregon is now always among the top ten states in the US having the highest rate of suicides in the US. In fact, Oregon had the 2nd highest suicide rate in the country between 1999-2010.” (Toffler & Stevens 2015)

Drs Toffler and Stevens’ claims are evidentially *false*.

Assisted dying opponents also commonly cite an econometric model of Oregon suicide rates published in the *Southern Medical Journal* (Jones & Paton 2015) to claim suicide contagion from the State’s assisted dying Act. Firstly, it’s important to establish that this modelling did *not* find a significant correlation between the rate of assisted deaths and general suicide. However, assisted dying opponents still quote the study to say there was a significant rise in suicides, a result that is only achieved by *adding* the assisted deaths to the suicide rate. That is an argument that A causes B, but only if you add A and B together; a logical fallacy.

Secondly, the modelling study contains numerous significant biases that invalidate any conclusions to be drawn from it. No fewer than six significant biases of the analysis will be explained in an upcoming journal article:

- *Premise bias*: equating a peaceful doctor-assisted death with an irrational and violent suicide;
- *Design bias*: deciding that econometric modelling was an appropriate analytical strategy when more direct data is readily available;
- *Execution bias*: failing to include major suicide risk and protective factors, while including minor ones and duplicating some;
- *Selection bias*: omitting data from a cited source that was in direct contradiction of the study’s premise, while including other data from the same source that appeared to support it;
- *Methodology bias*: making a minimal comparison with all other states combined, but not with comparable individual states; and
- *Interpretation bias*: implying a causative relationship between assisted dying and general suicide that was wholly unjustified by the study.

In another example of Authority bias, in official testimony before the Victorian Parliamentary inquiry into end-of-life choices, **Catholic Episcopal Vicar Anthony Ireland** said:

"We know, for example, since Oregon legislated, that the standard suicide rate has increased remarkably and alarmingly. It's not yet the largest rate in the US, but it's getting there, when Oregon had a very, very low suicide rate prior to that."

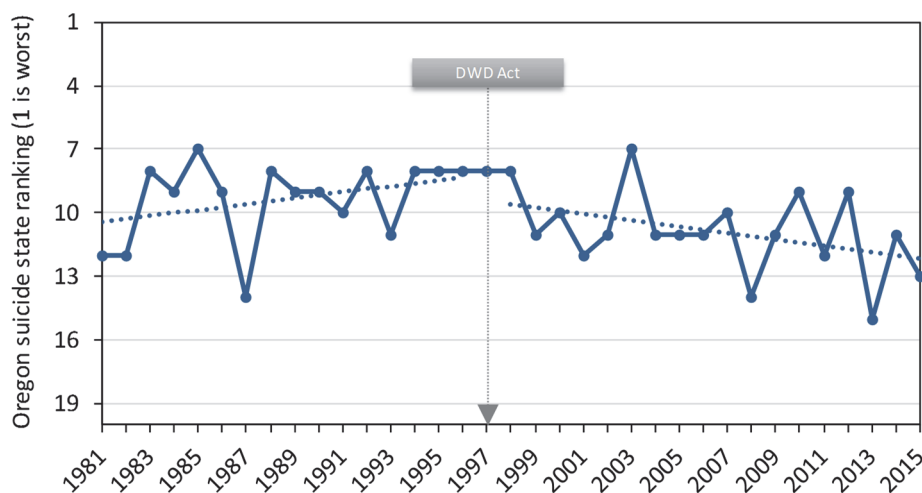


Figure 33: Oregon’s state ranking for suicide from 1981–2015

Source: CDC Wonder. Note: 1 is the highest (worst) suicide rank.

It is clear from Figure 30 that the Vicar’s statement is factually false, and by a large margin. As I’ve explained in full before, prior to Oregon’s Death With Dignity Act, its suicide ranking amongst USA states was worsening, while since the Act it has been improving (Figure 33) (Francis 2015).

Not in Switzerland

Assisted dying opponents also commonly neglect to refer to readily available Swiss data (Federal Statistical Office [Switzerland] 2012) shown in Figure 34, which also runs counter to the theory of suicide contagion. After the launch of Dignitas (who assist suicides) in 1998, the general suicide rate in Switzerland continued to drop.

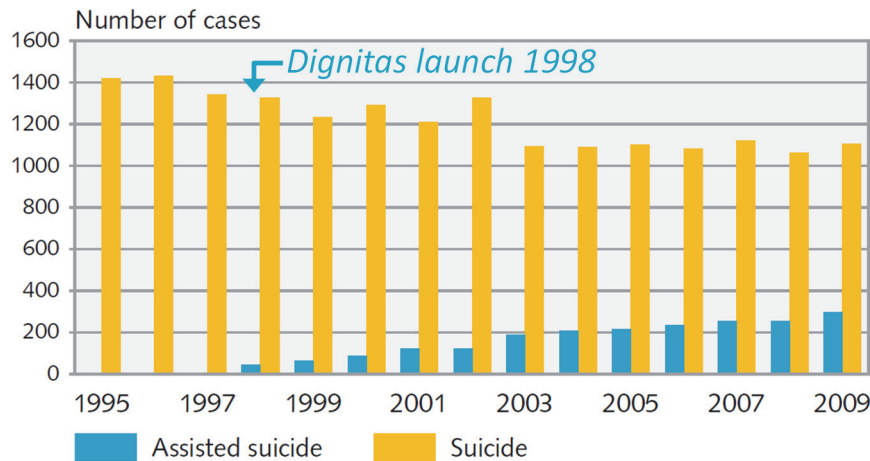


Figure 34: Swiss government suicide data 1995-2009

Source: Federal Statistical Office [Switzerland] 2012

Indeed, a longitudinal analysis of Swiss data comprehensively contradicts the “suicide contagion” theory (Figure 35).

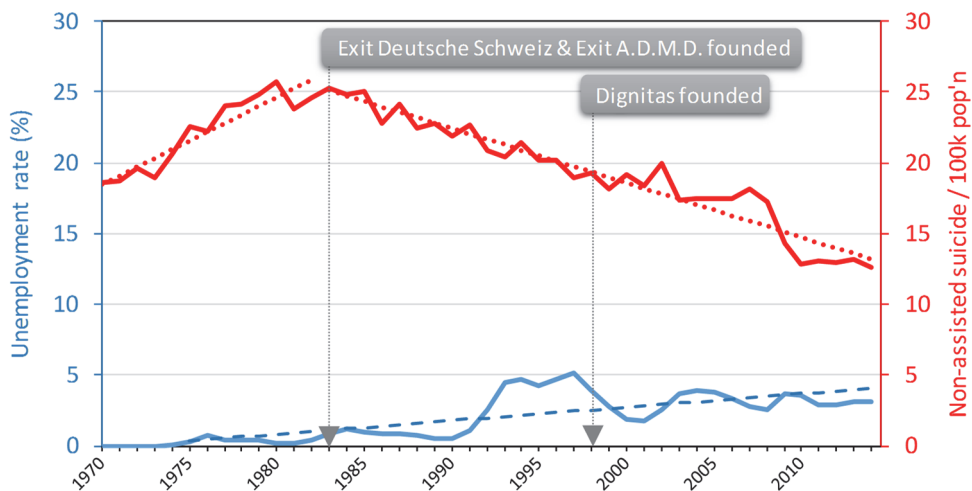


Figure 35: Swiss suicide and unemployment rates since 1970

Sources: Swiss Office for Statistics, FRED Economic Data

The Swiss suicide rate was increasing across the 1970s until 1983, when two assisted suicide associations were formed: Exit Deutche Schweiz for German speakers, and Exit A.D.M.D. for French speakers. Since the two associations were formed, the rate of general suicide has continued to drop, even in the face of rising unemployment (a known key contributor to suicide).

The rate has continued to drop even as Dignitas was founded in 1998 and has assisted deaths for an increasing number of foreign nationals.

It's obvious why assisted dying opponents fail to mention the Swiss experience: it's an *inconvenient truth*. It profoundly contradicts "suicide contagion" theory, especially for a legislative regime that has a *single* protection — that any assistance rendered for suicide must only be for non-selfish motives.

Not in the Netherlands

Data for the Netherlands is also an *inconvenient truth* for assisted dying opponents. Excellent longitudinal data from the Dutch statistical office shows that suicide rates trend strongly with unemployment (Figure 36).

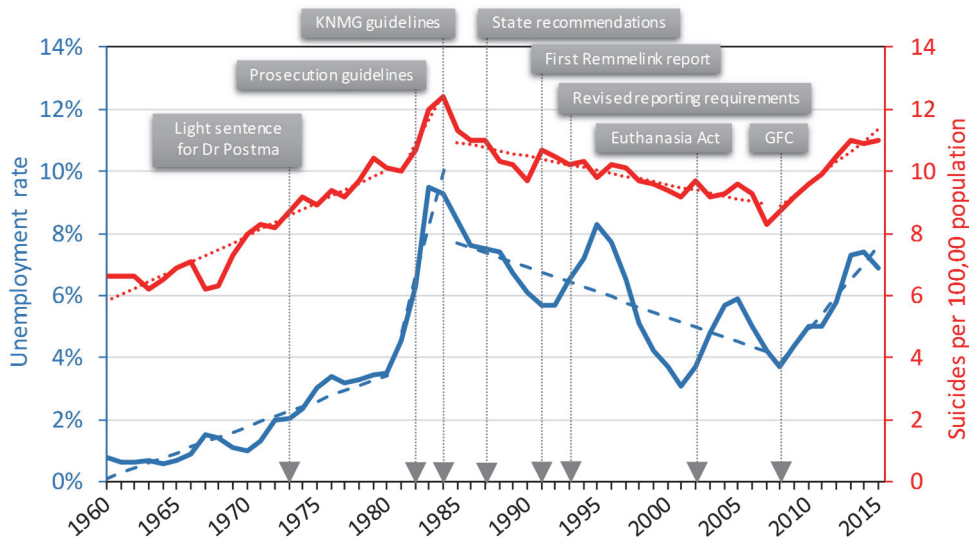


Figure 36: Dutch unemployment and suicide rates since 1960

Sources: Dutch Central Bureau of Statistics

Throughout the 1960s and 70s, assisted dying was illegal in the Netherlands. The highest-profile early public coverage of a physician assisted death came with the 1973 prosecution of Dr Postma, a physician who administered a lethal dose of morphine to her mother, paralysed by a cerebral haemorrhage, at her mother's persistent request. Dr Postma was found guilty of manslaughter and given a suspended jail sentence of one week (Griffiths, Bood & Weyers 1998, p. 51). Throughout this period both unemployment and the general suicide rate rose significantly.

In 1982, after considerable social and legal discussion and further criminal and medical disciplinary cases, the Board of Procurators-General — the most senior prosecutorial authorities in the nation — determined that cases of physician assistance would not be prosecuted provided some general requirements were met. The requirements were not crystal clear for medical practice itself, and the substantive legal grounds were still questionable (Griffiths, Bood & Weyers 1998, p.61). Both unemployment and the general suicide rate rose substantially.

In 1984, after further high-profile court cases, the Royal Dutch Medical Association (KNMG) published guidelines articulating a justification of necessity and requirements for careful practice, guiding doctors more clearly in assisting patient-requested deaths. This was the point from which an increasing number of doctors felt able to provide assisted dying. As numbers increased, the Dutch parliament commenced an investigation to legalise the practice by statute (Griffiths, Bood & Weyers 1998, p. 65).

Also during this period, both the unemployment rate and the general suicide rate generally trended downwards, and continued downwards for nearly a quarter century as assisted dying numbers increased.⁸

In 1987, the Council of State made further recommendations, and the Government submitted a revised Bill to fully legalise the practice (Griffiths, Bood & Weyers 1998, p. 75).

In the late 1980s a research Commission was appointed to research and report on physician assisted dying practice. The research Commission tabled its first results in 1991, known commonly as the Rummelink report.(Griffiths, Bood & Weyers 1998, p. 78) This led the Parliament, in 1993, to legislate a more comprehensive suite of reporting requirements for cases of assistance (Griffiths, Bood & Weyers 1998, p. 80).

In November 1998, as the annual number of reported cases passed 2,000, five regional Euthanasia Commissions were established to scrutinise every case in detail (van Delden 2004).

Further developments about the principles and details of particular cases continued, culminating in the legislature passing the *Termination of Life on Request and Assisted Suicide (Review Procedures Act)* in 2001 (Parliament of the Netherlands 2002). The Act came into effect in April 2002 (Adams & Nys 2003). For a further five years, the unemployment and general suicide rates continued to fall.

And then the global financial crisis (GFC) flared in the second half of 2007. The Netherlands, initially expected to weather the crisis well, was particularly hard hit because certain aspects of its economy which were formally strengths, became substantial weaknesses (Masselink & van den Noord 2009). The Dutch economy contracted sharply in 2009, following years of robust growth (International Monetary Fund 2011). Further, compared with other OECD countries, the Netherlands was reluctant to adopt stimulus measures, and those that it did adopt were small and late (Wanna, Lindquist & de Vries 2015, p. 170). Both the unemployment rate and the general suicide rate trended upwards. *This particular date range (from 2008) is the suicide data set that Prof. Margaret Somerville has wrongly used as her 'proof' of 'suicide contagion' in the Netherlands (Francis 2017c).*

In statistical terms, variance in the Dutch unemployment rate alone between 1960 and 2015 explains most (80%) of the variance in the Dutch general suicide rate (Pearson's $r^2 = 0.80$, $p < 0.001$), including a long-term downward trend in the general suicide rate in the first nearly quarter century of Dutch assisted dying practice.

Despite this readily-available evidence, Prof. Somerville made no discernible attempt to *test* her own 'suicide contagion' theory, instead merely noting an increase in the general suicide rate during the period of the GFC, for which the Netherlands was particularly hard hit, yet attributing the rise in suicides to assisted dying. At the same time, she overlooked her other data showing that the Dutch suicide rate was below the European average in 2013.

Further evidence also refutes the "suicide contagion" theory in regard to the Netherlands: there are five major regions in the Netherlands, each with assisted dying and general suicide figures available separately (Koopman & Putter 2016). Figure 37 shows a breakdown of assisted death and suicide rates by region in 2014.

⁸ The increase in unemployment in the early 1990s was not the result of retrenchment, but rather an increase of females wishing to enter the labour force: the Netherlands was at the time behind other European countries in female workforce participation. There was also the protective element of an excess supply of credit from 1994 to early 1997, and again between 2003 and early 2008. This would have helped 'soften' economic hardship from transient rises in the unemployment rate in those years. During other periods there was an excess *demand* for credit, particularly strong in 2009.(International Monetary Fund 2011)

The assisted death rate in the North-West region is significantly higher (6.0%) than all the others (mean 3.4%). The North-West region includes Amsterdam and surrounds, where access to physicians willing to consider cases of assisted death is higher, and the population will have the highest average level of education, a known factor amongst those who choose assisted dying.

However, the North-West region suicide rate (10.3 per 100k population) is second-*lowest*, lower than the mean of the other four regions (11.5).

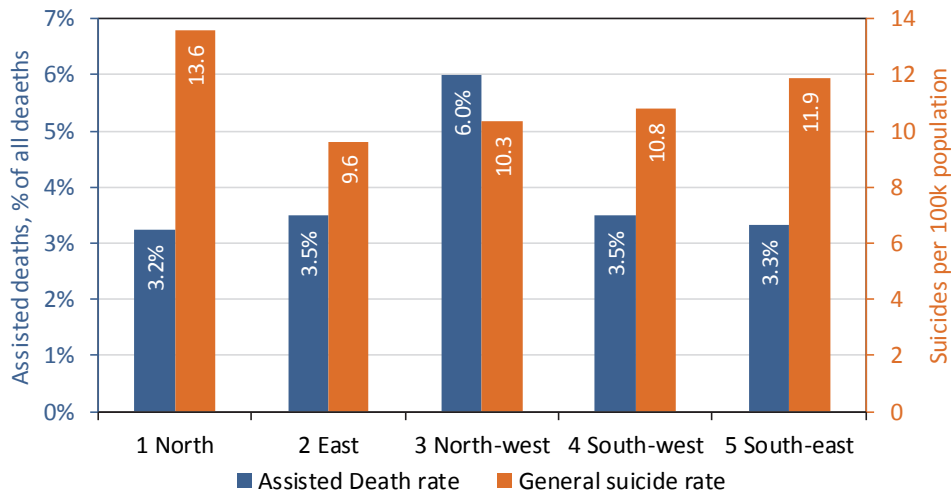


Figure 37: Assisted death and general suicide rates in the Netherlands, 2014

Sources: Koopman and Putter (2016), Dutch Government data, Euthanasia Commission report

Further, the North region had the lowest assisted dying rate (3.2%), yet the highest general suicide rate. These findings also contradict “suicide contagion” theory.

Not in Belgium

Unlike the Netherlands, assisted dying was completely illegal in Belgium prior to its Act, which came into effect in late September 2002 (Adams & Nys 2003). All the online, publicly available government data for unemployment and general suicide in Belgium are presented in Figure 38.

The unemployment rate shows that labour in Belgium, unlike the Netherlands, was unaffected during the GFC. The general suicide rate has substantially dropped since Belgium’s euthanasia Act came into effect.

Indeed, the data indicates that the general suicide rate is decreasing both *faster* than it did before the Act, and *faster* than the fall in unemployment rate since. Comparing the pre- with the post- data, the trends in unemployment and general suicide are statistically similar prior to the Euthanasia Act (1987–2001) ($p < 0.05$), but significantly different after it (2003–2013), ($p = 0.52$). For means, the post-unemployment rate is not significantly different from the pre- unemployment rate ($p = 0.60$), while the post- mean suicide rate is significantly lower than the pre- suicide rate ($p < 0.01$).

The data, too, contradicts assisted dying opponents’ “suicide contagion” theory. The data may even suggest a substitution of violent suicides with physician-assisted death for some who would qualify under the Act, though further research would be required to confirm such an interpretation.

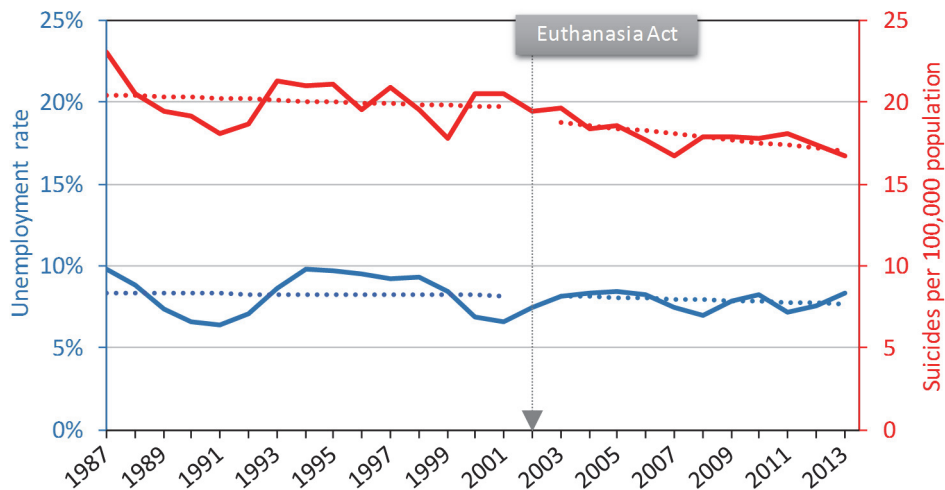


Figure 38: Unemployment and general suicide in Belgium 1987-2013
Sources: OECD Data; Eurostat

It is particularly disappointing that, given all the readily-available evidence which has been debated via the national broadcaster the ABC (Francis 2017c, g; Somerville 2017a, b, c), with a full analysis published previously (Francis 2017i), **Palliative Care Victoria**, in a recent “Resource for Victorian MPs” (Palliative Care Victoria 2017), cited only the Oregon study to claim that an increase in “total suicides”—in which they include assisted deaths—was “associated” with an increase in assisted deaths, while neglecting to mention other jurisdictions which soundly contradict their claim.

Government suicide data from multiple jurisdictions contradicts the theory that assisted dying legislation leads to ‘suicide contagion’.

Belgian nurses are like anywhere else

According to a booklet published by anti-euthanasia campaigner Alex Schadenberg, Belgian nurses often perform illegal “euthanasia without request” (Schadenberg 2013b).⁹ He lays the blame for this squarely at the feet of Belgium’s euthanasia law. He cites as ‘proof’ a point-in-time study of Belgian nurse behaviour (Inghelbrecht et al. 2010). Mr Schadenberg’s ‘findings’ are quoted widely by assisted dying opponents.

Curiously, **Palliative Care Victoria**, also in their “Resource for Victorian MPs” circulated during the Parliamentary debate on the *Voluntary Assisted Dying Bill*, cite the same point-in-time study to make a similar claim. But their conclusion from the study, like Alex Schadenberg’s, is no robust ‘analysis,’ because they ignore proper longitudinal studies from two different countries that contradict their claim.

Firstly, Mr Schadenberg’s ‘analysis’ cherry-picks statements from the research which help to prosecute the desired case, while omitting to mention ones that counter his theory. For example, his analysis omits to mention that the researchers said “*nurses may have thought that they were ending the patient’s life, when in fact the drugs were intended [by the prescribing doctor] to relieve symptoms in an aggressive, but necessary manner*”.

⁹ The booklet was launched in Australia by the Hon. Kevin Andrews, the federal politician who led the overturning of the Northern Territory *Rights of the Terminally Ill Act* in 1996/7 (Russell 2013).

These kinds of medical interventions are a facet of continuous deep sedation or palliative sedation, practiced around the world. There are still controversies, with some referring to it as ‘good palliative care’ or ‘intensified alleviation of symptoms,’ while others disagree. When it is practiced without an explicit request from the patient (because they are near death and are not mentally competent) *and* actually does shorten life (which commonly-used opioids generally don’t), it may be referred to as non-voluntary euthanasia (NVE).

So, did Belgian nurses overestimate their doctors’ *intentions* to hasten death? In a follow-up study, the researchers indeed found that Belgian nurses “*see it* [continuous deep sedation] *mainly as a practice intended to hasten death, with a life-shortening effect*”, when it may not have that intention (by the doctor) or had any life-shortening effect in any case (Inghelbrecht et al. 2011).

Secondly, the use of a single point-in-time study to make a causative assertion fails the most basic tenets of science.¹⁰ To prove causation, the first and most basic of several steps is to establish *correlation*. Did these nurse practices *begin* or at least *increase* from the time of the Belgian euthanasia Act (2002)?

Figure 39 shows the rate of nurse-administration of NVE in Belgium before and after the Euthanasia Act came into effect in 2002 (Bilsen et al. 2014). Clearly, the practice was well-entrenched long before the Act, and it went *down*, significantly, afterwards. This is clear and empirical evidence *against* correlation, so causation fails at the first hurdle of proof.

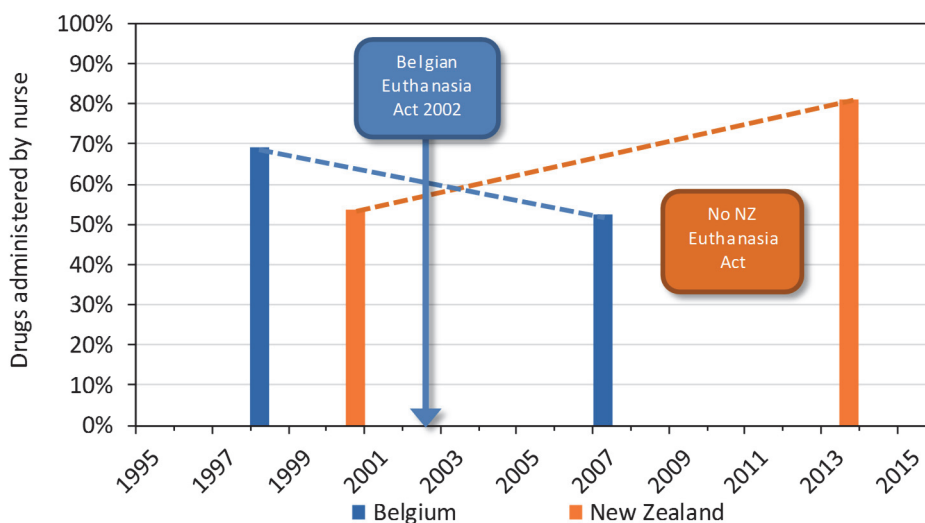


Figure 39: Nurse-administration of NVE (on physician instructions) in Belgium and New Zealand
Sources: Bilsen et al (2014); Mitchell & Owens (2004), Malpas et al (2015)

But there’s more. Figure 38 also shows nurse-administration of NVE in New Zealand (Malpas, Mitchell & Koschwanez 2015; Mitchell & Owens 2004), a jurisdiction on the opposite side of the world from Belgium and which has never had an assisted dying law.

Unambiguously, the rate of nurse-administration of NVE in New Zealand—which, remember, has no assisted dying law—has *increased* at the same time that Belgium’s has fallen. (Some caution is warranted in comparing the absolute values of the Belgian and New Zealand results because while the methodologies were similar, they were not identical. However, the within-country *trends* are highly significant.)

¹⁰ To describe this kind of ‘analysis’ as ‘junk science’ (an oxymoron) would be giving it more credit than it’s due. Such analysis is not science at all. It’s merely junk.

It's particularly disappointing that **Palliative Care Victoria** chose to circulate misinformation to MPs while positioning itself as expert on the subject matter (the Authority bias).

Multiple scientific studies provide ample evidence that nurse-administered sedation or NVE is not caused by an assisted dying law, but is rather a facet of medical practice culture.

Dutch happy to go to hospital

In the early 1990s a newspaper opinion piece claimed that the Dutch were fearful of going to hospital and carried 'do not euthanase me' cards. No evidence was provided and the claim was quickly dismissed.

Then, in a video made and promoted around 1995 by the International Anti-Euthanasia Task Force (now the 'Patients Rights Council') in the USA, Oregon nurse Donna Howell featured, categorically claiming that:

"It has gotten so bad in Holland that people have in their wallets little cards that say 'do not euthanase me without my permission'." (Patients Rights Council 2013)

The video is still promoted today as an authoritative exposé on euthanasia, and the claim is repeated frequently by opponents of assisted dying.

In in-person interviews I conducted in the Netherlands in 2012, I asked a range of people including legislators, doctors and researchers about this claim. All said it was a silly, untrue statement. I also put it to Dutch euthanasia law opponent, Theo Boer, who said:

"[Conservative USA Senator] Rick Santorum said that [too]. I know. Which is of course not true."



Oregon nurse Donna Howell is categorical: the Dutch carry little "don't euthanase me" cards.

And, Charoltte Ariese van Putten, policy officer for NPV, the Dutch Patients' Association which is also opposed to the Dutch euthanasia law, said politely:

"I think that is not really the case in the Netherlands that people who are going to the hospital that they should ask them not to euthanase them. But I heard about that quote."

Palliative Care Victoria made the same claim, except about *Belgium*, in its submission to the Victorian Parliamentary inquiry on end-of-life choices (Palliative Care Victoria 2015). Curiously, the claim had never before been made about Belgium — where it is no more true than it is for the Netherlands. Palliative Care Victoria cited as the authoritative source for their claim a report of conference proceedings of anti-assisted-dying campaigners, co-authored by David A. Jones (Gately & Jones 2014) (that's the same Jones of the Oregon "suicide contagion" econometric modelling study), which in turn alleges that Belgian anti-assisted-dying campaigner Dr Benoit Beuselinck had made the statement in a conference talk. No evidence of any kind has been offered in the chain of miscommunication: it has been simply and conveniently repeated (remember the Repetition bias) by anti-assisted-dying campaigners.

It's particularly disappointing that **Palliative Care Victoria**, an organisation that promotes itself as a subject-matter expert, has repeated such scuttlebutt without properly understanding its sources.

Claims that the Dutch (or now, supposedly, Belgians) carry 'do not euthanise me' cards, are fiction. Even self-identified opponents of the Dutch euthanasia law agree.

Groningen Protocol a wise policy

The Groningen Protocol is a Dutch regulation that specifies criteria for the potential termination of life in severely ill newborns in extremis with untreatable and unrelievable conditions, and who are assessed as unlikely to survive. In September 2006 the Netherlands formally adopted a Regulation incorporating the Protocol.

Unlike the Euthanasia Act that grew from public demand through to legislative action, the Protocol was initiated independently by Dutch paediatricians, to formalise how such difficult cases should be handled.

Despite the Regulation's development through extensive professional consultation, endorsement by the Dutch Paediatric Association, empirical data showing a decrease rather than increase in use, and research showing that neonatal euthanasia occurs around the world in the absence of regulation, the Dutch Regulation has sparked controversy.

While it has been widely claimed that 650 babies a year are killed under its provisions, forensic analysis reveals the claim to be comprehensively and evidentially false (Francis 2016b).

Wide online dissemination of the claim by mostly religious sources demonstrates confirmation bias and misinformation contagion.

Claims that hundreds of babies are euthanised in the Netherlands are false, as are claims the Groningen Protocol was a *consequence* of the Euthanasia Act. The Protocol's provisions are used less often than prior arrangements.

Theo Boer always an assisted dying law sceptic

Opponents of assisted dying hail Christian ethics Professor Theo Boer's criticism of Dutch euthanasia law as an apparent massive 'conversion' away from former support. The claims appear widely across the Internet as well as in Parliamentary submissions.



Theological professor Theo Boer outlines how he was a sceptic of the Dutch euthanasia law before being invited onto a euthanasia committee.

These claims are untrue according to Professor Boer himself. When I interviewed him on camera in Utrecht in 2012, he said:

"The interesting thing is that I was asked in [onto] the committee as being a euthanasia sceptic and I don't know whether you know a former Minister of Justice, Winnie Sorgdrager, she was my chairperson at that time, and I said 'haven't you read from my publications that I am a sceptic?'"

A brief video of this interview is available at DyingForChoice.com (Francis 2016d).

Curiously for an ethicist, Professor Boer fails to articulate sound reasons for why he says he thought it acceptable for 2,000 Dutch individuals in unrelievable extremis to seek and obtain a hastened death, but *not* acceptable for 4,000.

Theo Boer did not convert to scepticism over the Dutch euthanasia law.
By his own statements he was a sceptic from the outset.

Women are not vulnerable to voluntary euthanasia laws

In November 2010, the South Australian parliament was debating an assisted dying Bill. Professor Nicholas Tonti-Filippini (now deceased) of the John Paul II Institute in Melbourne wrote to all MPs outlining supposed reasons to oppose the Bill. In his letter he said, amongst other things:

“It is also distressing to note that two thirds of people lawfully killed under euthanasia laws, in those jurisdictions that permit it, are women.”

He provided no reference or source for the claim. In 2011, he and I published head-to-head commentaries in the Australian Christian Lobby’s headline magazine, Viewpoint (Francis 2011). Professor Tonti-Filippini largely reproduced his 2009 letter, with some citations for his claims.

The source for this claim was a 1996 book on gender, feminism and death (Wolfe 1996). The relevant citation appears on page 291 of the book, in which a psychiatrist “speculated” about the incidence of women among Jack Kevorkian’s assisted dying patients. This was merely an opinion published in a New York newspaper, *Newsday*, on November 25th 1992, an opinion seventeen years old at the time of Prof. Tonti-Filippini’s writing to South Australian MPs, and about a jurisdiction *without* assisted dying laws.

Empirical evidence at the time did *not* support Prof. Tonti-Filippini’s claim (Rurup et al. 2012). Nor does the latest data for Oregon, Washington, the Netherlands and Belgium (Figure 40).

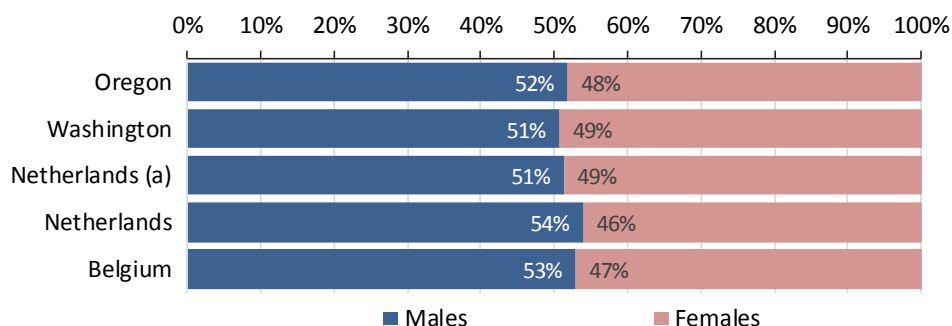


Figure 40: Use of assisted dying laws by gender

Sources: Oregon 1998–2016 annual DWDA reports; Washington 2009–2016 annual DWDA reports; Netherlands (a) 2016 Euthanasia Commission report (first year of M/F data); Netherlands and Belgium 2003–2007 Rurup et al. (2012)

In all jurisdictions, more males than females have used assisted dying. If opponents of assisted dying are to be consistent, they must now claim that *males* are ‘vulnerable’ to assisted dying laws. Why don’t they?

A consistent but modest majority of assisted dying law users are male.
Females are not ‘vulnerable’ as claimed by Professor Tonti-Filippini and others.

Victorian MP publishes extensive misinformation

Victorian MLC Mr Daniel Mulino is a member of the Legislative Council committee that investigated end-of-life options in Victoria. He did not participate in a global tour of the Committee visiting jurisdictions where assisted dying is lawful.

Instead, he provided a minority report against the recommendation of the majority of the Committee to legalise assisted dying. However, the report contains multiple serious errors of fact, which I have pointed out before (Francis 2017b).

In just four examples of serious errors in his report, Mr Mulino:

- Cherry-picks data from the Netherlands in a way that supports and exaggerates his case against assisted dying;
- Mismatches total death and assisted death data from the Netherlands in a way that supports and exaggerates his case against assisted dying;
- Misquotes half a sentence of a research report to say the exact opposite of what the full sentence said, in a way that supports his case against assisted dying; and
- Cherry-picks data out of a multi-country research report to make his case against assisted dying, when the data in the report undermined his case, as does longitudinal data from other reports he failed to include in his report.

I spoke at length with Mr Mulino about the misinformation and he acknowledged that he was indeed wrong.

These offences were all the more egregious for Mr Mulino's report having the appearance of a well-researched, cited and authoritative report, and his holding of a PhD in economics from Yale University, which would have given him the necessary skills to avoid such errors.

A report from a seemingly authoritative source and appearing scientific may still contain egregious misinformation.

Opponents admit no slippery slope 'cause and effect'

In an interview I and former Speaker of the Victorian Parliament, the Hon. Ken Smith, conducted with Drs Bill Toffler, Charles Bentz and Ken Stevens at St Vincent's Providence Hospital in Portland, Oregon, they made multiple claims of controversial medical practice in Oregon since the *Death With Dignity Act* came into effect (in 1997). However, these were medical practices that occur all over the world, and the doctors had provided at least one example of questionable conduct in Oregon *before* the Act.

Mr Smith and I challenged the doctors, that, given these practices happen everywhere and also occurred in Oregon before the Act, how could they assert that the Act was the *cause* of the controversial conduct?



Oregon doctor Bill Toffler and colleagues admit there's no proof for the 'slippery slope'.

Dr Toffler said:

"Now what we're saying is... it exists, the slippery slope, and can we prove cause and effect, of course not!"; and

"We can't show cause and effect. That's not what we're claiming."

These statements were not challenged by Drs Bentz or Stevens; the three sitting together.

Opponents of assisted dying law clearly have a strong *belief* in the 'slippery slope', but admit they have no evidence to support it.

Even opponents of assisted dying readily admit that there is no proof that legalising assisted dying leads to claimed slippery slope effects.

These are just a few examples of misinformation from opponents of assisted dying law reform. The Parliamentary Committee and its Secretariat must be sure not to take information provided to it as true merely by virtue of who communicated it (potential Authority bias) or how often it is repeated (potential Repetition bias).

Holding an extensive library of assisted dying literature on a full range of facets and research, I would be happy to assist the Committee at any time it needs verification of a statement or claim.

Recommendation 6:

That the Western Australia Parliament takes care to inform itself of and remains vigilant in regard to negative claims made about jurisdictions where assisted dying is lawful, to detect and reject claims which are false or misleading.

Part E: Potential models of assisted dying law reform

This section addresses Terms of Reference item 3.

Detailed information on existing assisted dying laws are published elsewhere, for example by Australia 21 (White & Willmott 2012), so I will not reproduce them here. However, it is useful to reflect on the three major forms of assisted dying law enabled through *statute*, on the basis of overseas experience.

Oregon/Washington model

This model is arguably the most 'restrictive' and has been in effect since 1997 (Oregon) and 2008 (Washington). It allows a person suffering intolerably from a terminal illness, and with six months¹¹ or less to live, to seek an assisted death. Multiple doctor opinions are required, the patient must be fully informed, and the patient must self-administer lethal medication.

Self-administration has the advantage of amply demonstrating it is the patient's will to hasten their death. A significant disadvantage is that the patient must be *capable* of self-administration. That means for example, that a Motor Neuron Disease or Multiple Sclerosis patient must self-administer while they still can, before their condition deteriorates and prevents them from acting. That causes some patients to hasten their death somewhat earlier than they may have otherwise chosen to, compared with if doctor- or nurse-administration were permitted.

Records of requests, prescription fulfilments and deaths under the Act are collected by authorities and a report of statistics is published annually. Professional experience of the Act is clear:

"The idea that people would come from outside of Oregon to access the law, the idea that it would be vulnerable and disenfranchised people who would make the choices, that it would be because they could not get good treatment for their pain or for their symptoms, those haven't been true." Prof. Linda Ganzini, Researcher and clinical psychiatrist.

"It [qualifying for assisted dying] is a long, somewhat arduous process and it's not surprising when they complain along the way about how this law makes it hard. And I will say that I am glad. The purpose wasn't to make it easy. It was to make it possible." Dr Peter Regan, has prescribed under the Act.

"We've had the experience: the sky didn't fall!" Ann Jackson, CEO of the Oregon Hospice Association for 10 years prior to the Act, and 10 years post.

Benelux model

Somewhat more permissive statutes exist in Belgium, the Netherlands and Luxembourg (with some differences between them). The Belgium and Netherlands laws have been in effect since 2002, and Luxembourg's since 2009. The laws allow a person suffering intolerably and without relief that is acceptable to them (not necessarily a terminal condition) to seek an assisted death. Multiple doctor

¹¹ The requirement of a doctor to determine that the patient has less than six months to live is *not* on the basis of a value judgement that it is "OK" to consider assisted dying at five months but not at seven months. It is on the basis that under USA Medicare arrangements, if the doctor reasonably concludes the patient has less than six months to live, then hospice care costs are automatically covered by the State. This then moves personal financial considerations to one side in the decision-making; high costs being a known facet of healthcare in the USA.

opinions are required and other statutory safeguards apply. Documentation regarding each assisted death case is reviewed by a special-purpose committee and cases investigated if statutory requirements are not substantively met.

In all three jurisdictions a doctor may administer the lethal dose at the patient's explicit request (AVE), or the patient may self-administer (PAD).

Swiss model

Switzerland has the world's oldest and most liberal assisted dying law, in effect since 1942. It is extremely simple and is restricted entirely to an exception provided in the Swiss penal code. Article 115 simply states (translated):

"Every person who shall for selfish motives encourage or assist another person to commit suicide shall be liable to imprisonment for a term not exceeding five years."

That is, assisting a suicide is not an offence provided it is done for non-selfish reasons.

There are no *statutory* requirements in terms of the reason the person has for wishing to end their life, nor checks and balances in terms of mental capacity or being fully informed, nor any procedural requirements to enact the assistance. Nevertheless, assisted suicides under the code were rare prior to the establishment of the first Swiss assisted suicide organisation, Dignitas, in 1998. There are now four other self-help organisations in Switzerland as well, each catering to a slightly different cohort of clients. Each organisation voluntarily operates in a measured and transparent way. For example, all Dignitas assisted suicide requests are assessed beforehand, and many declined. All suicide assistances are recorded and the death referred to police to ensure transparent practice.

Official government statistics show that since the foundation of Dignitas and others, that while assisted deaths has increased (many of which are of people from other countries), the rate of general suicide has decreased over the same period as shown in Figure 26.

The evidence is clear that even with more liberal assisted dying laws in effect for a long time the application of the law is measured and responsible.

Options for Western Australia

The Western Australia legislature may choose to adopt one of a number of different approaches to honouring the wish of the great majority of Victorians for assisted dying law reform. There are five broad options:

A. **A restrictive approach**

A new statute allows only the terminally ill to potentially qualify, via an arduous process, for self-administration only.

B. **A conservative approach**

A new statute allows those with a terminal illness or the advanced stage of a degenerative disease causing intolerable and unrelievable suffering to potentially qualify, via a rigorous process, for self-administration *unless the individual is incapable of doing so*, in which case a doctor may directly assist but only if the individual is currently mentally competent to confirm the request.

C. **A moderate approach**

A new statute allows those with terminal illness, an advanced degenerative disease, or incurable mental illness causing intolerable and unrelievable suffering to potentially qualify, via a rigorous process, for self- or doctor-administration while mentally competent.

D. **An inclusive approach**

A new statute allows those with a terminal illness, an advanced degenerative disease, incurable mental illness, or old-age multiple morbidities causing intolerable and unrelievable suffering to potentially qualify, via a rigorous process, for self- or doctor-administration. Request for an assisted death in certain circumstances may be made in advance through an Advance Care Directive.

E. **A liberal approach**

An exception is added to the criminal code on assisted suicide to allow any person to assist another to die, provided he or she does so for purely altruistic and compassionate reasons. Reasonable proof of the deceased's request, and grounds for altruism and compassion must be provided to the satisfaction of the coroner.

Overall, the extensive and professional consultation process conducted by the Parliament of Victoria and the Government of Victoria serve as useful models for the Western Australia Parliament to consider.

Recommendation 7:

That the Western Australia Parliament establish a public consultation on end-of-life choices to explore the range of options and provisions to form the basis of an assisted dying Bill, to have Parliamentary Counsel write the Bill, to introduce the Bill to Parliament and to take the Bill to a non-party vote.

Conclusion

Current Western Australia law on end-of-life decision making lags significantly behind the will of the people. In this submission, clear evidence has been provided of the extent and entrenchment of Western Australian and broader Australian desire for assisted dying law reform.

The current law is incoherent in regard to end of life choices, facilitating some choices whose purpose is to hasten death with few or no statutory safeguards, such as refusal of life-saving medical treatment and refusal of food and fluids, while prohibiting others — assisted dying — which are proposed with a comprehensive suite of safeguards.

Examples of how empirical evidence is contrary to ‘slippery slope’ theory, and opponents’ acknowledgement, have been provided.

I encourage the Committee to visit jurisdictions in which assisted dying is legal in one form or another, and speak directly with doctors, ethicists, legislators, researchers and others, to inform yourselves thoroughly. I personally know many of these people, and would be happy to assist with introductions if necessary.

I urge the Committee to work with their Parliamentary colleagues to formulate an assisted dying Bill to go before the legislature for a non-party vote.

I would be pleased to appear before the Committee to help inform its deliberations and to answer any questions Committee members may have.

The Committee may find a series of informational DyingForChoice.com videos helpful. They include:

- Palliative care can’t always help.
- The fiction of so-called ‘slippery slopes’.
- Parliament Bill has strong safeguards.
- An interview with Mr Peter Short and his wife Elizabeth. Peter, a Victorian, made a strong case for assisted dying law reform before dying of oesophageal cancer.

These videos are available at <http://www.dyingforchoice.com/resources/videos>.

Again, thank you for the opportunity to contribute in some small way to this important consultation.

Senator Ginny Burdick



Acting Senate President
Parliament of Oregon

"I would just encourage Victorians to give this [assisted dying] law a chance, to give it overwhelming support and to just reassure Victorians especially with your wonderful health care system in Australia, this is just a very, very positive addition to your health care options at the end of life.

It is a compassionate measure that will help a lot of people, whether or not they actually use it. It will help them have peace of mind at the end of their lives that they have control, they have dignity and they have the respect of your state to make their own decisions about the end of life."

Summary of recommendations

Summary list of recommendations that have appeared throughout this submission.

Recommendation 1

That the Committee and its Secretariat vigilantly avoid inadvertent bias in its decision making that may result from (a) emotions diminishing critical evaluation, (b) repetition giving rise to perceptions of validity and accuracy of misinformation, and (c) appeals to 'authority' giving rise to false impressions of 'evidence' quality, and to inappropriate exclusion of options.

Recommendation 2

That the Western Australia Parliament familiarise itself with the case for assisted dying law reform and the tragic consequences of denying Western Australians such a choice in the face of intolerable and unrelievable end-of-life suffering.

Recommendation 3

That the Western Australia Parliament familiarise itself with the extensive evidence of overwhelming public support for assisted dying, and that voters are likely to punish, at a general election, MPs who vote against a Bill to legalise assisted dying.

Recommendation 4

That the Western Australia Parliament familiarise itself with the diversity of views amongst healthcare professionals, and that the AMA's opposition to assisted dying fails to reflect a majority of its own members' belief that assisted dying should be provided by doctors if legalised.

Recommendation 5:

That the Western Australia Parliament takes care to inform itself about arguments against assisted dying which are illegitimate, incoherent, unsupported or indeed contradicted by empirical evidence, or amount to filibustering.

Recommendation 6:

That the Western Australia Parliament takes care to inform itself of and remains vigilant in regard to negative claims made about jurisdictions where assisted dying is lawful, to detect and reject claims which are false or misleading.

Recommendation 7:

That the Western Australia Parliament establish a public consultation on end-of-life choices to explore the range of options and provisions to form the basis of an assisted dying Bill, to have Parliamentary Counsel write the Bill, to introduce the Bill to Parliament and to take the Bill to a non-party vote.

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