

Submission to the Legal and Social Issues Committee of the Victorian Legislative Council on “End of Life Choices”

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Purpose of this submission

From a brief summary of the arguments in favour of voluntary euthanasia legislation, this submission looks at two reasons why it might be opposed and concludes that neither is persuasive. The submission considers especially the misleading and false arguments used by opponents.

Terms of reference

The terms of reference for the Committee's inquiry do not specifically mention voluntary euthanasia, but that should be a basic choice if people are legally to "exercise their preferences for the way they want to manage their end of life".

A dying person can legally choose palliative care, to withhold or withdraw medical treatment, to stop eating and drinking, to be put under terminal sedation, or to commit suicide.

Voluntary euthanasia is not legal in Victoria, but in my view (and the view of more than 70% of Victorians) it should be an option for someone who is suffering unbearably and incurably and who wants a doctor's help to die.

Definitions

Voluntary euthanasia, voluntary assisted dying, physician-assisted dying, physician-assisted suicide, medical aid in dying and dying with dignity are all terms used to describe essentially the same thing. They all involve a rational request by a terminally or incurably ill person for medical help to end his or her life painlessly and peacefully. A doctor may administer the medication, or prescribe it for the patient to self-administer.

Why voluntary euthanasia is good public policy

Briefly - voluntary euthanasia is:

- compassionate,
- a fundamental personal right,
- happening now,
- democratic, and
- it works.

Why should those in terminal and unrelievable pain be forced to suffer when death is inevitable? Why is it compassionate and "humane" to euthanase our dying and suffering pets but not our dying and suffering fellow humans who are asking for help?

Voluntary euthanasia should be a matter of personal choice. No-one has more right than the individual to decide how, when and where he or she dies.

It is a personal matter both for the patient and the health professional. Existing and proposed voluntary euthanasia legislation does not ask or require anyone to do anything against their will.

Voluntary euthanasia has been practised long before it became legal in some countries. A survey in Australia showed that about a third of doctors have, for compassionate reasons, helped patients to die. (See C D Douglas et al, "The intention to hasten death: a survey of attitudes and practices of surgeons in Australia", *Medical Journal of Australia* 175: 19 November 2001, page 513.)

Why should doctors risk prosecution because they act to relieve suffering? Why should a compassionate act not be transparent and accountable?

Voluntary euthanasia should be agreed public policy because it is demonstrably in accordance with the wishes of a very substantial majority of electors and because overseas experience (especially in Oregon since 1997, and in the Netherlands and Belgium since 2002) shows convincingly that assisted dying legislation works safely and effectively. Safeguards in the laws protect the vulnerable from abuse.

The Opposition

I want to focus on two possible reasons for opposing voluntary euthanasia, and on whether these reasons are persuasive.

Religious belief

The Catholic Church regards voluntary euthanasia as a sin that is never acceptable. It denies the right of its members to make an ethical choice on assisted dying, as it does on such matters as birth control, women priests and same-sex marriage.

The opposition to voluntary euthanasia comes much more from the Church's institutional hierarchy than from individual Catholics. A Newspannoll in 2012 showed that 77 per cent of Australian Catholics (and 82 per cent of Anglicans) believe in legal voluntary euthanasia. (See YourLastRight.com, "Australian public desire for legal assisted dying" (2012)). Clearly, the Church hierarchy speaks to, but not for, its flock.

The dying with dignity movement does not generally argue with the Church about theology or dogma - although the Australian group Christians Supporting Choice for Voluntary Euthanasia points out that voluntary euthanasia is quite consistent with Jesus's message of love and compassion and with his Golden Rule: "In everything do unto others as you would have them do unto you" (Matthew 7:12).

Supporters of voluntary euthanasia do not ask Church institutions and associated groups like the Australian Christian Lobby to change their beliefs, simply that they respect the beliefs of others and allow choice.

This may be too big an ask of people who believe that they and they alone possess the one truth.

However, in a secular and democratic society the religious views of people should not determine public policy, even though they must of course influence their personal end-of-life choices.

The “slippery slope”

Setting aside opposition to voluntary euthanasia for religious reasons, there are continual claims that a so-called “slippery slope” will ensure that calamity will befall society if a first step to change is taken.

These claims need to be tested against the empirical evidence accumulated after decades of experience in Oregon, the Netherlands and Belgium.

Some fear that the numbers of those seeking an assisted death will burgeon, that the vulnerable will be abused, that voluntary euthanasia will lead to non-voluntary euthanasia or involuntary euthanasia, and that voluntary euthanasia will adversely affect funding for palliative care.

None of these fears has been realised.

Numbers

Where voluntary euthanasia legislation exists, very few people actually avail themselves of their legal right to die with dignity. Despite fears to the contrary, the floodgates have not opened.

In 2008, the Hundere Professor in Religion and Culture at Oregon State University wrote that the number of people who had used the Death with Dignity Act in Oregon “are not only lower than the substantial numbers predicted by opponents, they are even smaller than the more conservative estimates anticipated by advocates.” (See Courtney S. Campbell, “Ten Years of “Death with Dignity”, *The New Atlantis*, Fall, 2008, page 36).

Now, after 17 years of experience in Oregon, 1327 people have received prescriptions under the Act, and of those, 859 people have actually used the prescription to end their lives. Over the period from 1998 to 2014, the annual number of prescriptions has gradually increased from 24 to 155. In 2014, 105 prescriptions were used, 32 more than in 2013. (See the 17th annual report of the Oregon Public Health Division at <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>)

How should those figures be interpreted? The Catholic Herald in the UK certainly found them a cause for alarm.

Under the heading “Assisted suicides soar in US state”, the Catholic Herald concluded excitedly that “Deaths by assisted suicide in Oregon have soared by a huge 44 per cent in the past year alone”. (See <http://www.catholicherald.co.uk/news/2015/02/20/assisted-suicides-soar-in-us-state-held-up-as-model-by-euthanasia-lobby/>)

Statistics are wonderful things and wonderfully capable of being manipulated. It is worth looking more closely at a wider range of the yearly figures to see whether the Catholic Herald’s emotive reporting was in any way fair and reasonable.

The numbers of prescriptions issued from 2010 to 2014 were 97, 114, 116, 121 and 155 respectively. The numbers of prescriptions actually used were 65, 71, 85, 73 and 105.

It would have been just as valid (or misleading) for the Catholic Herald to reassure its concerned readers by saying:

- From 2011 to 2012, the number of prescriptions issued increased by less than 2 per cent
- From 2012 to 2013, the number of prescriptions issued increased by a mere 4 per cent
- From 2012 and 2013, the number of prescriptions actually used **fell** dramatically by 14 per cent.

More significantly, the Catholic Herald did not mention at all a much more relevant statistic: the number of assisted deaths as a percentage of the total number of deaths.

The 2014 figure was a miniscule fraction of all deaths in Oregon that year - about 0.3 per cent. Nor did the Catholic Herald point out that even that tiny figure would have been reduced by a full third, to 0.2 per cent, if it had looked only at the 2013 numbers.

One would have to conclude, not surprisingly, that the Catholic Herald was not at all interested in providing a comprehensive factual description of the Oregon experience with voluntary assisted dying.

Fears of abuse

There have been, understandably, concerns about the possibility or probability of adverse effects of voluntary euthanasia laws, and the need for safeguards.

Protection for the vulnerable is of course essential, but that is not inconsistent with giving terminally-ill people the choice to ask for help to die.

Probably the most frequent claim by opponents of voluntary assisted dying laws is that their introduction has led and will lead to abuse of vulnerable groups. The inference is that greedy relatives and unscrupulous doctors will combine to coerce people into dying prematurely for financial or other material gain.

For example, Cardinal George Pell has written: “Euthanasia actually undermines the human dignity of everyone who is sick, vulnerable, dependent or disadvantaged. They become disposable, burdens, too expensive to keep.” (See “You Shall Not Kill”, Catholic Communications, Sydney Archdiocese, 10 June 2011.)

There is no evidence to support this view. The contrary is the case.

In Oregon, the people who have used the law have mostly been white, educated and insured (and by implication well-off). The vast majority died at home under hospice care. ((See the 17th annual report of the Oregon Public Health Division referred to above.)

A study in 2007 concluded that the “rates of assisted dying in Oregon and in the Netherlands showed no evidence of heightened risk for the elderly, women, the uninsured,...people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities” (Battin, M et al., “Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in “vulnerable” groups”, *J Med Ethics* 2007;**33**:591-597).

A comprehensive review of assisted dying legislation in 2011 found that “there is no evidence from the Netherlands supporting the concern that society’s vulnerable would be at increased risk of abuse”. (Report by Royal Society of Canada Expert Panel, *End-of-life Decision-making* November 2011).

Similar conclusions were reached by the Quebec Parliament’s Select Committee on Dying with Dignity (2012) and the independent Australian think tank Australia21 in its report *The Right to Choose an Assisted Death* (2013).

In other words, there is no evidence of any coercion of dying people for personal or organisational gain.

One might have hoped that this lack of evidence would have led Cardinal Pell to admit that his views as expressed in 2011 were unwarranted.

Unsurprisingly, the Catholic Church has repeated these unjustified fears, e.g. the submission of the Catholic Bishops Conference to a Federal Senate Committee inquiry in 2014 said: “Legalised euthanasia endangers the lives of people who are seriously ill, elderly, disabled, have low self-esteem or are otherwise vulnerable”. (See <https://www.catholic.org.au/acbc-media/downloads/public-policy/papers/1705-20-august-2014-inquiry-into-the-exposure-draft-of-the-medical-services-dying-with-dignity-bill-2014/file>)

Constant repetition of an error does not make it true, but it is a sad reflection of the Church’s unwillingness to engage in honest debate.

Non-voluntary euthanasia

Non-voluntary euthanasia is a good example of a practice that opponents of voluntary euthanasia use to argue - illogically - against the introduction of voluntary euthanasia laws.

The term “non-voluntary euthanasia” is often muddled with “involuntary euthanasia”. “Non-voluntary euthanasia” occurs when a patient has not given explicit and current consent for help to die. It is by definition not performed under any voluntary euthanasia law, as those laws all require an explicit and written request from the person seeking a doctor’s help to die. It is nevertheless technically illegal.

“Involuntary euthanasia” occurs when someone is killed against their will, i.e. murdered.

Some opponents of assisted dying claim that a voluntary euthanasia law will **inevitably** lead to involuntary euthanasia.

For example, Cardinal Pell has written: “Just as winter follows autumn legislation to allow voluntary euthanasia or mercy killing would lead to widespread involuntary euthanasia, with many, perhaps a majority of those euthanized being subject to the procedure without their consent and often against their will”. (See “You Shall Not Kill”, Catholic Communications, Sydney Archdiocese, 10 June 2011.)

This statement not only muddles non-voluntary euthanasia and involuntary euthanasia, but is false.

There is no evidence at all of any connection between assisted dying legislation and people being murdered.

There is similarly no evidence to support the view that voluntary euthanasia leads to non-voluntary euthanasia.

In fact, where there are authoritative figures, the incidence of non-voluntary euthanasia is falling, not increasing.

A review in 2009 found that in the Netherlands “the frequency of ending of life without an explicit patient request decreased from 0.8% of all deaths in 1990 to 0.4% in 2005 (approximately 550 cases annually)”. (See Rietjens J et al. (2009) “Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?” *Journal of Bioethics Inquiry* 6(3): 271–283).

By 2010, the rate had fallen further, to 0.2 per cent. (See Onwuteaka-Philipsen, B. D. et al. (2012), “Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey”, *The Lancet*, Vol 380, Iss 9845, (8 Sep) pp 908-915.)

The situation in Belgium is very similar.

“After a decrease from 3.2% in 1998 to 1.8% in 2007, the rate of hastening death without an explicit request from the patient remained stable at 1.7% in 2013.” So far from increasing, the percentage of deaths that were facilitated by doctors without the

person's direct request actually dropped by about half since the introduction of a voluntary euthanasia law. (See Kenneth Chambaere et al "Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium", *N Engl J Med* 2015; 372:1179-1181 March 19, 2015 DOI: 10.1056/NEJMc1414527 at <http://www.nejm.org/doi/full/10.1056/NEJMc1414527?query=OF&&>)

Not only are opponents factually wrong about the incidence of non-voluntary euthanasia, neither do they explain the context of these decisions. Instead, like Cardinal Pell, they simply make bald and seriously misleading half-truths, such as that in 2005 in the Netherlands 550 people were euthanized without an explicit request.

It might be inferred from Cardinal Pell's statements that doctors are malevolently ending many people's lives. But in fact, their motives have been compassionate. There have been no prosecutions.

The patients concerned had not sought to use the euthanasia law, but were typically very close to death and mentally incompetent. And there had been an earlier discussion about hastening death with them and/or their relatives. (See Alphen, J E et al., "Requests for euthanasia in general practice before and after implementation of the Dutch Euthanasia Act", *British Journal of General Practice* 60:573, April 2010, pp 263-267).

Likewise, where non-voluntary euthanasia did occur in Belgium, it happened "predominantly in hospital and among elderly patients who are mostly in an irreversible coma or demented". In these cases, doctors had apparently acted "to abbreviate extreme suffering in patients who are unable to express themselves any more", usually with the tacit assent of family and nursing staff. (See Kenneth Chambaere et al "Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium", referred to above).

Again, no-one has been prosecuted. Common sense and humanity have prevailed over the technical letter of the law.

There is no evidence of a causal relationship between voluntary euthanasia and non-voluntary euthanasia or involuntary euthanasia.

However, if there is a correlation between the existence of voluntary assisted dying laws and the incidence of non-voluntary euthanasia, the unavoidable conclusion is that it is a positive one. Open and transparent voluntary assisted dying legislation will make this more, not less, likely.

Palliative Care

Opponents of voluntary assisted dying sometimes claim that skilled palliative care is enough to address the wishes and needs of people asking for help to die.

This is false.

For example, Palliative Care Australia's position statement (2006) on voluntary euthanasia "acknowledges that while pain and other symptoms can be helped, complete relief of suffering is not always possible, even with optimal palliative care."

More recently, the Canadian Medical Association "recognizes that there are rare occasions where patients have such a degree of suffering, even with access to palliative and end of life care, that they request medical aid in dying". It now "believes in those cases... that medical aid in dying may be appropriate."

(Quoted in the article "Canada top court allows doctor-assisted suicide", The West Australian, 7 February 2015,

<https://au.news.yahoo.com/thewest/world/a/26220278/canada-top-court-allows-doctor-assisted-suicide/>)

Voluntary euthanasia and palliative care are not antagonistic alternatives; they are complementary. For evidence of how this works in Belgium, see Bernheim, J. et al, (2008) 'Development of palliative care and legalisation of euthanasia: antagonism or synergy?' *British Medical Journal*, 336(19 Apr), 864-867.

Opponents of voluntary assisted dying sometimes claim that voluntary euthanasia laws will lead to reduced funding for palliative care.

For example, the Catholic Bishops Conference claimed in 2014 that "Where euthanasia is legalised it becomes a competing option with palliative care" (again, see <https://www.catholic.org.au/acbc-media/downloads/public-policy/papers/1705-20-august-2014-inquiry-into-the-exposure-draft-of-the-medical-services-dying-with-dignity-bill-2014/file>).

The evidence is to the contrary.

A 2010 survey by the Economist Intelligence Unit that assessed end-of-life care across the world ranked the palliative care systems in Belgium and the Netherlands fifth and seventh respectively. In Oregon in 2009, over 90% of those who chose an assisted death were already housed in high quality hospice care.

In 2011, the European Association for Palliative Care produced a report entitled "Palliative Care in Countries with a Euthanasia Law" that concluded "the idea that legislation of euthanasia and/or assisted suicide might obstruct or halt palliative care development...seems unwarranted" and is not demonstrated by empirical evidence.

Conclusion

These are but a few instances of false or misleading arguments that amount to intellectual dishonesty. If opponents are aware of the evidence in favour of voluntary euthanasia, why do they wilfully and repeatedly distort the facts? Is it because they are basically driven by their faith, but realise that to rest their case on that foundation is an inadequate and inappropriate determinant of public policy in a secular democracy?

I would of course be happy to expand on any of the above.