Submission

to the

Parliament of Victoria
Standing Committee on Legal and Social Issues
(Legislation and References)

on the

Inquiry into End Of Life Choices

from

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Dear Mr O’Donohue,

Thank you for the invitation and opportunity to contribute to the Standing Committee on Legal and Social Issues inquiry into end-of-life choices. The inquiry is valuable and timely, since Victoria’s laws lag significantly behind the will of the people, and in places are somewhat incoherent.

I run DyingForChoice.com, 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 4,000 professional journal and other articles on assisted dying and related topics.

This submission:

- Examines the Medical Treatment Act 1988 (Vic) and offers several recommendations for improvement;
- Presents substantial evidence of the long-term and robust desire of Victorians and Australians for responsible assisted dying legislative reform;
- Articulates primary research evidence that refutes supposed ‘slippery slope’ arguments advanced against assisted dying law reform by opponents;
- Explains examples of unpersuasive arguments and mistaken information commonly used by opponents, and how they fail, including an acknowledgement from opponents that they do indeed fail;
- Briefly describes the major forms of assisted dying legislative frameworks in force around the world today;
- Proposes a broad set of legislative alternatives for consideration and development into a specific Bill to go before the Victorian legislature; and
- Offers assistance to the Committee’s work and deliberations.

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 Victoria to allow citizens to make informed decisions regarding their own end of life choices.

And in particular to:

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, 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; and
3. Consider what type of legislative change may be required, including an examination of any federal laws that may impact such legislation.

Remarks

Sections of this report identify the terms of reference they address as numbered above.

The terms of reference provided to the Committee by the Legislative Council create constraints to the inquiry:

a. By referring to ‘citizens’, the terms of reference might be read to restrict law reform for end-of-life decision making to only people who are native or naturalised members of Victoria. However, 11.3% of Victorian residents are not citizens (State Government Victoria 2012). Further, there are millions of interstate visits to Victoria each year (Tourism Victoria 2015a), plus more than two million international visitors (Tourism Victoria 2015b). All these people are expected to abide by the laws of the State while here. To avoid legal discrimination, which may be unconstitutional or offend the Charter of Human Rights and Responsibilities Act 2006 (Vic), this submission will assume that the terms of reference are read to apply to any and all persons present in Victoria at the time end-of-life decisions need to be made.

b. While legislative reform is certainly necessary, many opportunities to improve end-of-life decision making may occur through regulation or through government policy. However, these are not specifically provided for in the terms of reference. For example, effective initiatives to improve doctor-patient-family conversation skills at end of life result not only in lower use of intensive care services, but help achieve better quality of death (Zhang et al. 2009). Insights such as these can help governments formulate effective policy, but are not legislative reforms. This report largely addresses legislative reforms, since those are the terms of reference.

c. The terms of reference specifically and only articulate “own end of life choices” (Terms of Reference 0). Where a person has lost mental capacity to participate in current decisions about health care, the law requires clarification about substitute decision making, already partly addressed in the Medical Treatment Act 1988 (Vic). Some aspects of this are addressed in this submission.
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.
Part A: Correcting anomalies in the Medical Treatment Act

This section addresses Terms of Reference 0, 2 and 3. It addresses several anomalies that arise from provisions in the Medical Treatment Act 1988 (Vic) (“the Act”), with recommendations for improvement.

Refusal of medical treatment to include palliative care

Currently the Act provides statutory protection for the right of a patient to refuse any unwanted medical treatment (S1a). No reason need be given by the patient. A healthcare worker who administers interventions in contravention of a properly formulated refusal certificate is guilty of the offence of ‘medical trespass’ (S6), for which penalties may apply.

However, the Act does not afford the patient the right to refuse palliative care (S4.2). This is anomalous because palliative care is defined in the Act as ‘medical procedures’ (S3), which a reasonable person may interpret as ‘medical treatment’. The Act is silent on which medical procedures are ‘medical treatment’ and which are ‘palliative care’. Indeed, the same procedure (say, surgery or radiotherapy to attempt reducing the size of a tumour), could be deemed both or either.

If the doctor defines the treatment as palliative care but the patient defines it as unwanted medical treatment, may the doctor nevertheless administer the treatment or be open to prosecution? The most important consideration is the patient’s view of whether the intervention is acceptable or not.

Recommendation 1:
Revise the Medical Treatment Act 1998 (Vic) to clarify a statutory right to refuse all and any unwanted medical treatment, procedures or interventions.

Treatment refusal for future medical conditions

The Act currently permits refusal only for current medical conditions. This means that patients are denied statutory protections if they wish to plan ahead for either anticipated possible conditions (e.g. a new medical condition likely to arise from a progressive disease), or unexpected conditions (e.g. permanent vegetative state arising from a stroke or severe head trauma). Having spoken with thousands of people about the Act over a decade, it is my experience that this is the most criticised aspect of the Act: it profoundly fails to meet the expectations of Victorians.

Recommendation 2:
Revise the Medical Treatment Act 1998 (Vic) to equally support refusal of medical treatment for future conditions as well as current conditions.

Statutory protection of Advance Care Directives

The Act provides for the appointment of a substitute decision maker—Enduring Power of Attorney (Medical Treatment): ‘agent’—in advance of losing the ability to participate in the individual’s own medical decisions. However, the Act is silent on Advance Care Directives (ACDs): a valuable instrument that documents the patient’s expectations and wishes about contexts in which medical treatment may be welcome or refused. This is vital documentary evidence that helps inform the agent’s and others’ decision-making.

While ACDs have received increasing protections via several State Supreme Courts in Australia, statutory protection of a documentary instrument giving clear evidence of the patient’s preferences would add both consistency and legal clarity to decision making, at the same time as reducing the
need for expensive and time-consuming litigation to ensure a patient’s documented choices are honoured. Victoria is significantly behind other jurisdictions in this matter.

**Recommendation 3:**

*Revise the Medical Treatment Act 1998 (Vic) to recognise and afford statutory protection to clearly-constructed Advance Care Directives.*

In addition, different statutory provisions for ACDs across Australia create concern and confusion for citizens. If a citizen of one State or Territory falls seriously ill elsewhere in Australia, will their ACD be recognised and honoured, or ignored?

**Recommendation 4:**

*Continue and accelerate national Advance Care Planning and Advance Care Directives harmonisation so that all Australians can be assured their wishes will be respected when they are unable to directly participate in their medical care decisions.*

Of course, an ACD is of no use if its existence is unknown or the correct current version cannot be produced quickly and reliably in time of urgent need.

**Recommendation 5:**

*In concert with other States and Territories, develop and deploy a secure online repository system for ACDs into which healthcare and legal professionals may tap for authoritative information when the need arises for a patient.*
Part B: Assisted dying law reform

This section addresses Terms of Reference 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 must be established at the outset: the patient and only the patient may make a decision to elect for an assisted death for themselves. No person or organisation may make such a decision on behalf of someone else.

Avoiding common decision-making biases

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 has already received a large number of submissions which may give rise to unintended biases. Three key biases are discussed here.

Bias: Strong emotional language diminishes critical faculties

Strong and emotional language and expressed certainty in regard to ‘slippery slopes’ and how ‘the vulnerable’ will supposedly be ‘at risk’ from assisted dying law reform appears in numerous submissions.

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 in numerous submissions.

Bias: Repetition doesn’t make a falsehood true

The inquiry has received hundreds of submissions opposing assisted dying law reform, making a range of highly repetitious claims. Indeed, it is clear that many of these submissions are form letters in which cohorts of people have been given ‘talking points’ and cut and pasted selections into their own submission.

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).

Bias: 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 has 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).
This report provides examples of ‘authorities’ making statements that are untrue or misleading. The Committee and Secretariat must remain vigilant so as not to be misled by such statements by virtue of the stater’s apparent ‘expertise’.

**Recommendation 6:**
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’ and inappropriate exclusion of options.

**Assisted dying law reform is necessary**
The Committee has 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 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 (The Economist 2010).


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]
“...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 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, and the rate serves as a useful proxy measure.
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).

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)

The Hon. Ken Smith (Lib., Bass) and I spent a week in Oregon, USA, interviewing people about their 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.”

And since the Death With Dignity Act came into effect?

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

Clearly, Victorians, 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 non-availability of a peaceful, doctor-assisted death drives some terminally ill individuals to suicide using violent and undignified means.*

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

“There are technologies that can save life, they 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 Victorians get closer to 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.

By contrast, however, in the face of refractory and intolerable symptoms, 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). 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 Victoria, and across 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 2: Assisted deaths as a proportion of all deaths — illegal assisted dying in Australia three quarters the rate of legal Dutch practice](image)

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); and even in conservative Greece (Voultsos, 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 unground 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.

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

Overwhelming public support for law reform
Repeated and longitudinal research shows high levels of public desire for assisted dying law reform. National public opinion has been in the majority for around half a century, with very high levels for at least two decades (Francis 2012).
Support for assisted dying law reform in 2012 was high across age groups, education and region. These 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.

Support in Australia was also high across religions, and particularly high among the non-religious. Three out of four Catholics and four out of five Anglicans support assisted dying choice, placing vocal clerical opposition in stark contrast to the views of their flocks.

How is this so? 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.
Support was high across voting intentions, too, with an overwhelming majority of all party voters in favour of choice. But how important is the issue to voters?

Respondents were asked how personally important a raft of eight policy areas were (not whether they supported or opposed the policy). All policy areas received a significant majority rating as ‘more important’. After the NDIS and asylum seeker boat arrivals—burning issues consuming vast media attention at the time of the survey—assisted dying law reform was the next most important, ahead of the personal importance of abortion, the death penalty, the national broadband network, carbon emissions management, and same-sex marriage.
Contrary to conventional political wisdom, the attitudes of assisted dying supporters is on average more deeply entrenched than are attitudes of those opposed. **Voters opposed to assisted dying law reform were nearly twice as likely to rate the issue as less important.** So how might this translate into votes at the ballot box?

Respondents were also asked whether, at a general election, if their otherwise usual candidate’s stance on assisted dying were the opposite of their own, they would change their vote. **On average, an election candidate supporting law reform would stand to gain from supporter voters nearly four times the votes lost from opponent voters.** For Coalition candidates the gain is more than two times, for Labor candidates it is nearly five times, and for Greens candidates it is more than seven times.

In **Victorian** research, an **ABC Vote Compass** survey of more than 60,000 Victorian voters at the time of the **2014 Victorian State** election found more than three quarters of Victorians are in favour of assisted dying choice for the terminally ill. Support is high across the spectrum including age, gender, education, income, region, religion, and voting intention (Stayner 2014).
Figure 11: Support for assisted dying by gender, Victoria 2014, Vote Compass

Figure 12: Support for assisted dying by education, Victoria 2014, Vote Compass

Figure 13: Support for assisted dying by weekly income, Victoria 2014, Vote Compass

Figure 14: Support for assisted dying by region, Victoria 2014, Vote Compass

Figure 15: Support for assisted dying by religion, Victoria 2014, Vote Compass
Numerous polls by other researchers confirm the strong and sustained support of voters for assisted dying law reform.

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, religion 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. On average, an election candidate supporting law reform would stand to gain from supporter voters nearly four times the votes lost from opponent voters.

Voter support for assisted dying law reform is in the very great majority, is more deeply held than is opposition to reform, and translates to a net loss of votes for opposed election candidates.

Victoria’s youth more in touch

Assisted dying law reform is not just a matter for the silver hair brigade. 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.

- 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.
When the youth of Victoria can develop, introduce, debate and successfully pass assisted dying legislation four times out of four, it’s time for the adults do it once.

Opposing arguments critiqued

Time to name up filibustering for what it is
Opponents of assisted dying law reform often claim that there is no ‘rush’ for assisted dying law reform. A typical example is Fr Branko Brennan, who says that “there is no hurry” and that it is “presently an academic issue” (Brennan 2011). Not only does repeated research (reported earlier in this submission) clearly demonstrate otherwise, but the large number of submissions urging the Committee to move forward on the issue—despite the Terms of Reference not explicitly mentioning assisted dying—demonstrate community expectation and anticipation.

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 and 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). It is not value-neutral: it’s filibustering.

Claiming that that we need yet more information and can eternally deliberate is a delaying tactic.

Hippocratic Oath fictions
The Committee has received numerous submissions opposed to assisted dying argued on the basis that assistance is said to contravene 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.

It is hardly surprising 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 (World Medical Association 2006), which doesn’t outlaw or even mention assisted dying. Others, 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 & Dowton 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 has 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 ‘harm’s’. 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 the likelihood of each), 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 protected in statute in Victoria.

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 conflict, and even purpose 4 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 does not ‘save money’**

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

This is not only a shabby imputation of shallow self-interest, but fails to understand interests in a real-world context. 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 has received numerous 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 Lawerence 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.

Ample evidence against ‘slippery slope’ theories
Many submissions to the Committee that voice opposition to assisted dying law reform 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.

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 on the next page).

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.

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 20: The ‘vulnerable’ are not sometimes at risk, they are by definition always at risk](image)

Therefore it’s a circular sham to argue that a group becomes itself on the basis of some arbitrary change. We could equally say:
“The vulnerable will be at risk if we wear yellow socks on Wednesdays.”

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

Examples:


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”.


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.

**Unsupported by overseas evidence**

An international, peer-reviewed study into hypothetical “vulnerable” groups has showed 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), but the critique is flawed and unpersuasive. For example, while Finlay and George assert that the elderly are ‘vulnerable’ in Oregon, empirical data shows otherwise (Figure 21).

Oregon Health Authority statistics show that the use of the Death With Dignity Act peaks among 65-74 year-olds. If ‘elderliness’ were a vulnerability, use of the Act would trend upwards for increasing age groups, but the rates for 75+ year-olds are less than for 45-64 year-olds. In fact, the situation in Oregon is consistent with Belgian data, which shows a similar profile for assisted dying and for cancer deaths in that country (unpublished data). This is hardly surprising since the great majority of people who use assisted dying law have advanced cancer.
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 offendee can pull a hypothetical future injury out of the air.” (Pinker 2008)

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

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. In the early 1990s, the Royal Dutch Medical Association published guidelines for doctors to clarify requirements. 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, when 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.

In addition, Switzerland has had an assisted suicide law in effect since 1942.

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 take it that at least some forms of NVE practice are ‘problematic’ and it is desirable that they occur at a lower rather than higher incidence.
So, do we have a snapshot of NVE rates prior to the Dutch and Belgian euthanasia Acts coming into effect? The answer is yes, through a major international collaborative study using the same methodology across eight countries (van der Heide et al. 2003).

![Figure 18: Non-voluntary euthanasia rates in late 2001](image)

The important information we can glean from this research includes:
- Switzerland’s NVE rate is average, despite it having the world’s oldest assisted suicide law.
- 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.

Research clearly shows that the rate of NVE is not correlated with assisted dying laws. It is more likely to be correlated with the country’s underlying culture of medical practice.

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 give us insights into what happened to NVE rates after law reform (Bilsen et al. 2009; Onwuteaka-Philipsen et al. 2012; Seale 2009a).
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.

Despite the clear empirical evidence, many submissions to the Committee have 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).

Research clearly shows that NVE has decreased after statutory legalisation of assisted dying.

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

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2 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 involuntary euthanasia. 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.

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) 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 the doctor. (These provisions are just a small proportion of a raft of safeguards crafted in all assisted dying laws proposed in Australia.)

The 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 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.

In the more than quarter century of the operation of the Act, how many prosecutions have there been under Section 5F of the Act? Data from Victoria Police is revealing:

Exactly none.

A patient may also choose to die by voluntary refusal of food and fluids (VRFF). The option is legal in Victoria, 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 very hostile reception from the audience, requiring intervention by moderator Simon Longstaff.³

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 for 27 years with no prosecutions under the Act) or to refuse food and fluids until death (currently legal).

There’s more. The 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 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.

³ Later, online, ‘Paul Russell’ posted the comment: “Was Bill deliberately trying to make Al Qaeda look compassionate or was that simply incidental?”
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 elder abuse’s commission.

**Figure 22: Three identical contexts of theoretical ‘vulnerable’ slippery slopes, two of which are currently legal [VRFF = Voluntary Refusal of Food and Fluids]**

It is ethically and logically indefensible to hold up two of these models as acceptable and sound in the context of ‘vulnerability’, while criticising and rejecting the third one with more safeguards. Indeed we can say that:

**In permitting a range of choices, when it’s the same slope we must apply the same scope.**

**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, and not some 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.

In countless addresses I have given over the past ten years, I have asked for a show of hands as to who in the audience believes it is appropriate for a doctor to *stab and slash* their patients. Needless to say, hardly a hand has risen except for the few who knew what I was going to ask next: the same question using different language. Who believes that surgery can be appropriate? All hands rise.

This is no trivial parlour game: it’s a clear example of the evolution of social attitudes. Surgery was banned by the Hippocratic Oath due to exceptionally poor outcomes (infection and other complications or harms). For many centuries, surgery in Western society was deemed low-order slashing and stabbing. 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.

Construction of 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.

Correcting misinformation
Misinformation from opponents of assisted dying law reform is imaginative, highly varied, frequently stated and widely broadcast (remember the repetition bias). Many varieties have appeared in numerous submissions to this inquiry.

This submission has already provided ample evidence against the ‘slippery slope’, the subject of common erroneous beliefs. What follows are some other facets about which misconceptions are commonly held. The list is merely 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 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, she 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 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)

She made the statement categorically, yet when challenged by a member of the audience that it was untrue, Somerville 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 (footage on file), 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.”

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 this inquiry. It has also been used incorrectly 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).

It is false to claim that Dr Els Borst regrets the Dutch euthanasia law reform. She has directly 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.”

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.
No suicide contagion

Figure 23 shows official Oregon government census data on suicides in that state. The chart includes all data available through the Oregon government’s web portal (Oregon Health Authority 2012). 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 23: Oregon government suicide census data.](image)

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 24 adds the available USA Bureau of Labor Statistics for Oregon (Bureau of Labor Statistics (USA) 2014).

![Figure 24: Oregon unemployment rate (purple data).](image)

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)
Figure 25: Alex Schadenberg refers only to a sub-set of the data that appears to confirm his theory.

Notice that Mr Schadenberg refers only to data since 2000. If we look at the official data as from this date, illustrated in Figure 25 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. Mr Schadenberg also omits to refer to readily available Swiss data (Federal Department of Home Affairs (Switzerland) 2012) shown in Figure 26, which also runs counter to his theory. After the launch of Dignitas (who assist suicides) in 1998, the general suicide rate in Switzerland continued to drop.

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 as to the nonsense of his 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)
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). 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. But this is no scientific analysis.

Firstly, the ‘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".

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. 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 27 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.

But there’s more.

Figure 27 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 which has never had an assisted dying law. (The methodology of the Belgian and New Zealand studies was substantially the same.)

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4 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).

5 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.
Figure 27: Nurse-administration of NVE in Belgium (before and after the Act) and in New Zealand.

Unambiguously, the rate of nurse-administration of NVE in New Zealand—which, remember, has no assisted dying law—in 2000 was similar to that in Belgium. And, thirteen years later still in the absence of an assisted dying law, the rate has increased.

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 the culture of medical practice.

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 Howe featured, categorically saying 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.”
And, Charollette 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.”

A recent incarnation of the claim goes to even more bizarre lengths. In a paper by Professor David Jones from the UK Catholic institution the Anscombe Bioethics Centre, the assertion athletically hurdles the border into Belgium (Anscombe Bioethics Centre 2014). As before, no source or evidence is provided.

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

Theo Boer always an assisted dying law sceptic

Numerous submissions to this inquiry have heralded Christian ethics Professor Theo Boer’s recent criticism of Dutch euthanasia law as an apparent massive ‘conversion’ away from former support. The claims appear repeatedly across the Internet as well.

These claims are untrue according to Professor Boer himself. When I interviewed him on camera in Utrecht in 2012 (video on file), 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?’”

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 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

What is the actual proportion of males and females using voluntary euthanasia and physician-assisted dying laws? Empirical evidence from the Netherlands, Belgium and Oregon is readily available and does not support Professor Tonti-Filippini’s claim. The most current empirical research evidence comes from the Netherlands and Belgium (Rurup et al. 2012) and from Oregon (Oregon Health Authority 2015).

In all three jurisdictions, consistently more males than females use assisted dying. If opponents of assisted dying are to be consistent, they must now claim that *males* are ‘vulnerable’ to assisted dying laws. It might be revealing to ask “why don’t they”?

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

Opponents admit no slippery slope ‘cause and effect’

In an interview 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.

The Hon. Ken 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?
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.

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

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.
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 C: Potential models of assisted dying law reform

This section addresses Terms of Reference 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 months 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 fulfilsments 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). BeNe laws have been in effect since 2002, and Lux 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 opinions are required and other

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6 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 State 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 financial considerations to one side in the decision-making; high costs being a known facet of healthcare in the USA.
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.
Senor 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.”
Options for Victoria

The Victorian 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.

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 assisted suicide criminal code 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.

**Recommendation 7:**

*So that the law no longer lags significantly behind the will of the people—that the Parliament of Victoria consider 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 Victorian 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 Victorian and Australian expectations 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), while prohibiting others 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 recommend the Committee 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.

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, including the presentation of a short video of interviews in jurisdictions where assisted dying is legal, and to answer questions.

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.
Summary of recommendations

Summary list of recommendations that have appeared throughout this submission.

Recommendation 1:
Revise the Medical Treatment Act 1998 (Vic) to clarify a statutory right to refuse all and any unwanted medical treatment, procedures or interventions.

Recommendation 2:
Revise the Medical Treatment Act 1998 (Vic) to equally support refusal of medical treatment for future conditions as well as current conditions.

Recommendation 3:
Revise the Medical Treatment Act 1998 (Vic) to recognise and afford statutory protection to clearly-constructed Advance Care Directives.

Recommendation 4:
Continue and accelerate national Advance Care Planning and Advance Care Directives harmonisation so that all Australians can be assured their wishes will be respected when they are unable to directly participate in their medical care decisions.

Recommendation 5:
In concert with other States and Territories, develop and deploy a secure online repository system for ACDs into which healthcare and legal professionals may tap for authoritative information when the need arises for a patient.

Recommendation 6:
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’ and inappropriate exclusion of options.

Recommendation 7:
So that the law no longer lags significantly behind the will of the people—that the Parliament of Victoria consider 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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