Australian CareAlliance

"Care and Compassion: Opposing Assisted Suicide."

Submission
to the Legislative Assembly of the Northern Territory Legal and Constitutional Affairs Committee Inquiry into Voluntary Assisted Dying in the NT
by the Australian Care Alliance

The Australian Care Alliance was formed in March 2018 by health professionals, lawyers and community activists who had worked together informally to oppose the passage of the Voluntary Assisted Dying Bill 2017 through the Parliament of Victoria.

This submission addresses the four key questions set out in the Consultation Paper by assessing the evidence gathered from other jurisdictions, in Australia and internationally, that have legalised the prescription, provision and administration of a lethal substance for the purpose of ending a person's life.

Following the decision in *Carr v Attorney-General (Cth) [2023] FCA 1500*[1] and the practice of the World Medical Association[2] this submission refers to the prescription of a lethal substance to be self-administered for the purpose of ending a person's life as "assistance to suicide" and the administration by a medical or other health practitioner of a lethal substance for the purpose of ending a person's life as "euthanasia". Both these acts are legal under the euphemistic term "voluntary assisted dying" in each of the Australian States and – from 5 November 2025 – the ACT.

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[1] https://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/FCA/2023/1500.html?context=1;query=Carr%20v%20Attorney;mask_path=au/cases/cth/FCA

[2] https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/

1. Do you support making VAD legal in the NT?

Legalising assistance to suicide and euthanasia in the Northern territory would require creating exceptions to the criminal law on murder and on assisting suicide which currently protects every person in the Northern Territory.

Section 159 provides a mandatory sentence of life imprisonment for murder, defined as conduct which causes the death of another person where the person engages in the conduct intending intends to cause the death of that person by that conduct.

Section 162(1 (a) of the *Criminal Code Act 1983* provides a maximum sentence of life imprisonment for a person who "assists another person to kill or attempt to kill himself or herself".

Creating an exception to these laws requires a high standard of certainty that doing so will not lead to unavoidable harms such as wrongful deaths.

Scrutinising the evidence from the 29 jurisdictions which permit (or have permitted) euthanasia and/or assistance to suicide leads to the conclusion that they are all fatally flawed[3] as they each fail to exclude the twelve categories of wrongful deaths[4], including wrongful deaths as a result of medical errors, by coercion and by suicide contagion.

This evidence is set out below in Appendix A.

Given that there is no model for the legalisation of assistance to suicide, euthanasia or both that would guarantee no wrongful deaths, such legalisation is not justified.

Additionally, the claim by those who advocate for legalisation that it would only apply to a small number of people who cannot be helped by palliative care, who are certainly going to die within six months and who choose it freely is not borne out by the evidence. There is no jurisdiction where the numbers have stabilised – they are increasing year on year everywhere. Pain or physical suffering is not a major reason for request for assistance to suicide or euthanasia but loneliness, feeling like a burden on one's family and a desire to be in control are significant factors. Coercion is real and is not adequately addressed in any jurisdiction.

2. What eligibility criteria should a person need to meet before they can access VAD?

Jurisdictions in Australia (except the ACT) limit eligibility to those people who two doctors assert have a terminal illness that will likely cause the person's death within six or twelve months, and who freely choose to end their life or have their life ended by administration of a lethal substance. No jurisdiction can exclude medical errors in diagnosis or prognosis so the key eligibility criteria may not always be met.

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[3] https://www.australiancarealliance.org.au/flawed_experiments

[4] https://www.australiancarealliance.org.au/wrongful_categories

Coercion cannot be ruled out under any of the systems in place under voluntary assisted dying laws in Australia or elsewhere.

The other criterion – that the person is suffering – is meaningless because it merely needs to be stated by the person requesting assistance to suicide or euthanasia. This means people with mental ill health such as depression are particularly vulenerable.

The evidence supporting these views is set out below in Appendix A.

3. **How could the NT make sure that an eligible person can access VAD in a safe and effective way, including people living in remote areas, and Aboriginal and Torres Strait Islander people?**

The previous experience in the Northern Territory with the Rights of the Terminally ill Act 1995 demonstrates just how unsafe legalised euthanasia was in the Northern Territory, including its adverse impact on the health of Aboriginal people.

This submission also draws from a detailed analysis of how the Rights of the Terminally Ill Act 1995 operated when it was in force in the Northern Territory for nine months from 1 July 1996 to 27 March 1997 and includes a summary of that analysis as Appendix B.

Only four people were killed under its provisions. Of these there is evidence in three cases (75%) of untreated depression or other mental health issues; in one case (25%) that the person was not terminally ill and in two cases (50%) that further treatment could have relieved their condition. In none of the four cases (0%) was there any evidence of uncontrolled pain.

In a speech given in the Senate on 28 October 2010 on the *Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2010,* Senator Chris Back (WA, Liberal) said:

> *I actually communicated at length this morning with a senior surgeon from Darwin, Dr David Gawler.[T]the point he made to me was:*
>
> > *Importantly, if Indigenous people think medical staff have the power to terminate lives, the fear and distress will prevent many Aboriginal people from seeking and accepting medical treatment.*
>
> *He went on to tell me that, bearing in mind Indigenous cultural and linguistic differences, there may be 'insurmountable problems' in ensuring in each and every case that they have fully informed and have given consent for euthanasia. He makes the point that Aboriginal people do not enjoy good standards of health and are most frequent users of health services.*
>
> *If I can quote these figures, the Northern Territory has the smallest population of the Australian states and territories, the highest proportion of Aborigines within that—27 per cent was the last figure I saw—but almost 50 per cent of deaths in the Northern Territory are of Aboriginal people.*

> *Dr Gawler is of the belief the proposed legislation puts at risk the most vulnerable members of the population, and that is Aboriginal people in the Territory.*
>
> *It is interesting that in a paper in 1997 in the Lancet, John Collins and Frank Brennan agreed very much with Dr Gawler on the adverse effect on Aboriginal people in the Northern Territory of euthanasia. They report that the traditional Aboriginal viewpoint prohibiting euthanasia was rejected by the Northern Territory parliament as an argument against the act at a time of heightened concern around Australia about Aboriginal self-determination and health. The healthcare systems for Aboriginal patients are part of a unique complex which includes description of wellbeing, cause of illness, healing practices and the prerequisite social behaviours that a person experiences. They said at the time that the Northern Australian Aboriginal Legal Service admitted that euthanasia and suicide were not well known or understood in Aboriginal culture and that the most non-English-speaking Aborigines in the Territory were being denied their opportunity to make informed comment or response to the proposed legislation at that time due to a lack of interpreters.*
>
> *It was interesting to note the similarity between the concerns expressed by Collins and Brennan in 1997 and those of Dr Gawler to me this morning. He then went on to talk about intervention by outside agents under Aboriginal law and the possible concern associated with payback.*

The likely impact of a law permitting euthanasia or assistance to suicide on the health of Aboriginal people in the Northern Territory was also eloquently expressed by Senator Pat Dodson (WA, Labor) in his speech delivered in the Senate on 15 August 2018 opposing the *Restoring Territory Rights (Assisted Suicide Legislation) Bill 2015*:

> *We know that Australia's attempt to achieve the realisation of that right, through the Closing the Gap campaign, has been an abysmal failure. First Nations people do not enjoy the same quality of life in this country at every stage of their existence, as shown in the national figures. In the womb, a First Nations child is at higher risk of contracting life-threatening bloodborne diseases. Last year, six First Nations babies died of syphilis. Our children are more likely to be diagnosed with chronic health conditions such as type 2 diabetes. They are at greater risk of contracting meningococcal and rheumatic heart disease. As teenagers, they watch their friends, their cousins and their siblings prematurely end their own lives. These facts are true of the Northern Territory and nationally. In the Kimberley region, where I come from, the suicide rate is the highest in the world.*
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> *By what most Australians call middle age, many First Nations people are already living with kidney failure, without sufficient access to dialysis. The burden of disease and disability in First Nations communities is far higher than it is in the general population. First Nations people are more likely to live with a severe or profound disability. They also die younger. On a national basis, First Nations men can expect to live to an average age of 69, while non-First Nations men can expect to live to 80.*

> *First Nations women can expect to live to an average age of 73, while non-First Nations women can expect to live to 83.*
>
> *All governments—state, territory and federal—have failed to enact the necessary action to close the gap. The government is currently undertaking a refresh process, with the Minister for Indigenous Affairs announcing at Garma earlier this month that some two dozen new targets would be added as part of the refresh process. That seems a drastic amount of new targets, and only emphasises how we've failed to address the health issues suffered by First Nations people to date. With so many of our people suffering complex health conditions at an early age, there is a desperate need for culturally appropriate palliative care services in regional and remote areas. A review recently commissioned by the Australian government confirmed that more needs to be done to ensure that First Nations people are receiving palliative care within their communities.*
>
> ***Where First Nations people are already over-represented at every stage of our health system, it is irresponsible to vote in favour of another avenue to death. Paving the way for euthanasia and assisted suicide leaves First Nations people even more vulnerable, when our focus should be on working collectively to create laws that help prolong life and restore their right to enjoy a healthy life.***

Senator Jacinta Nampijimpa Price also addressed this question in a speech in the Senate on8 September 2022:

> *The Northern Territory has the highest proportion of Aboriginal Australians in the country, at 30 per cent of our population. The majority of this population consists of those whose first language is not English and who experience the lowest levels of education, the highest levels of unemployment and welfare dependency, the lowest life expectancy, the highest rates of domestic and family violence and the greatest health challenges in the nation. Voluntary assisted dying is incompatible with the Closing the Gap health and wellbeing targets of closing the gap in life expectancy within a generation by 2031, and significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero.*

4. **How could the NT monitor the process to ensure VAD is delivered safely and effectively?**

Australian jurisdictions such as Victoria require a permit to be issued before a lethal substance is prescribed for the purpose of causing death. The process is essentially one of checking the doctor applying for the permit has filled out all the forms and ticked all the boxes. These processes do not actually monitor safety at all. The Netherlands and Belgium have a more thorough monitoring process – but only after the person is already dead and there is no remedy for the person.

There is no system so far proposed that would ensure that assistance to suicide and euthanasia were safely delivered.

Addressing the underlying concerns of those who may request euthanasia or assistance to suicide should be a priority for the Northern Territory Government rather than offering Government permission to intentionally cause a person's death. This requires more work on the provision of palliative care for all Territorians and for strengthening efforts under the Suicide Prevention Implementation Plan.

RECOMMENDATIONS

Recommendation 1: The Committee should make a finding that it is not possible to enact a scheme which permits voluntary assisted dying, that is assistance to suicide and euthanasia, understood to be a scheme which allows the prescription and supply of a lethal dose of a substance to a person for the purpose of causing the person's death by self-administration or practitioner administration, which can guarantee that there are no wrongful deaths.

Recommendation 2: The Committee should recommend that the Northern Territory Government not proceed with the introduction of any legislation that would permit assistance to suicide or euthanasia.

Recommendation 3: The Committee should recommend that the Northern Territory Government take steps to improve access to gold standard palliative care for all Territorians, including those living in remote communities and Aboriginal and Torres Strait Isalander people.

Recommendation 4: The Committee should recommend that the Northern Territory Government, as part of its Suicide Prevention Implementation Plan, continue to address risk factors that may underlie requests for euthanasia or assistance to suicide from the elderly or from persons who are terminally or chronically ill or have a disability.

APPENDIX A. TWELVE CATEGORIES OF WRONGFUL DEATH NOT PREVENTED IN ANY OF THE 29 JURISDICTIONS WHICH HAVE LEGASLIED ASSISATCNE TO SUICIDE AND/OR EUTHANASIA

MEDICAL ERROR AND LACK OF QUALIFICATIONS/EXPERIENCE

All "voluntary assisted dying" laws in Australian jurisdictions include eligibility criteria which require a diagnosis or a terminal illness and a prognosis of either six or twelve months until death from that illness or condition is likely.

Go Gentle founder, Andrew Denton, admitted:

> *There is no guarantee ever that doctors are going to be 100% right.* [5]

1. Wrong Diagnosis

In a 2017 article Quassim Cassam found that "*physician overconfidence is a major factor contributing to diagnostic error in medicine*" This cannot *"be remedied by increasing physician self-knowledge"* because "*Some epistemic vices or cognitive biases, including overconfidence, are "stealthy" in the sense that they obstruct their own detection."*[6]

According to Dr Stephen Child, Chair of the New Zealand Medical Association:

"*On diagnosis, 10 to 15 per cent of autopsies show that the diagnosis was incorrect.*".[7]

Deaths following legal administration of a lethal poison are fallaciously attributed to the "underlying condition" and generally no autopsies are carried out.

Italian magistrate Pietro D'Amico, whose family insisted on an autopsy, was found not to have had a terminal illness, despite being given such a diagnosis by Italian and Swiss doctors prior to assisted suicide in Switzerland.[8]

The Northern Territory Rights of the Terminally Ill Act [ROTI Act] (Section 3) defines that: "*'terminal illness', in relation to a patient, means an illness which, in reasonable medical judgment will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient*."

In case 4 of a series of studies of the four deaths under the ROTI Act, there was no consensus that the person was terminally ill. The person was diagnosed with mycosis

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[5] https://youtu.be/VvsN47Uqbt0

[6] https://www.nature.com/articles/palcomms201725#auth-Quassim-Cassam

[7] http://www.stuff.co.nz/national/politics/84252580/euthanasia-toofinal-when-the-risk-of-error-is-to-great--doctors

[8] https://www.thelocal.ch/20130711/assisted-suicide-in-question-after-botched-diagnosis

fungoides. “*One oncologist gave the patient’s prognosis as 9 months, but a dermatologist and a local oncologist judged that she was not terminally ill. Other practitioners declined to give an opinion. In the end an orthopaedic surgeon certified that the ROTI provisions for terminal illness had been complied with*.”[9] This is a 25% error rate.

Peter Sefton-Williams, aged 71, began planning his assisted suicide with Dignitas in Switzerland after two specialists diagnosed him with motor neurone disease. He was told not to make any plans beyond six months. A few months later further tests showed that he had been misdiagnosed. He did not have motor neurone disease but Multifocal Motor Neuropathy, a mild condition that is not terminal and which, in most cases, is treatable.[10]

2. Wrong Prognosis

A study on the accuracy of prognoses in oncology found that “*discrimination between patients who would survive for one year and those who would not was very poor*”.[11]

A study published in 2000 in the British Medical Journal found that physicians were overly pessimistic in their prognosis by a factor of 2 in 11.3% of cases.[12] **More than one in ten people given a prognosis of 12 months to live may live for 2 years or more**.

In Washington, in each year between 5% and 17% of those who die after requesting a lethal dose do so more than 25 weeks later, with one person dying nearly 3 years later.[13]

In Oregon the longest duration between initial request and ingestion recorded is 2 years and 9 months.[14]

Dr Kenneth Stevens wrote:

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[9] Kissane, D W, Street, A, Nitchske, P, “Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia”, *The Lancet*, Vol 352, 3 October 1998, p 1097-1102

[10] https://www.spectator.co.uk/article/my-false-diagnosis-exposes-a-key-flaw-in-the-assisted-dying-bill/

[11] https://www.sciencedirect.com/science/article/pii/S0895435696003162

[12] http://www.bmj.com/content/bmj/320/7233/469.full.pdf

[13] Washington State Department of Health, *Death with Dignity Act Reports,* 2009-2017 available at: http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData

[14] Oregon Public Health Division, *Oregon Death With Dignity Act: 2018 Data Summary, Table 1,* p.13 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

> *Oregon's assisted-suicide law applies to patients predicted to have less than six months to live. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live.*
>
> *At our first meeting, Jeanette told me that she did not want to be treated, and that she wanted to opt for what our law allowed – to kill herself with a lethal dose of barbiturates.*
>
> *I informed her that her cancer was treatable and that her prospects were good. But she wanted "the pills."*
>
> *I asked her about her family and learned that she had a son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated, and her cancer was cured.*
>
> *For her, the mere presence of legal assisted suicide had steered her to suicide.*[15]

Jeanette Stevens has already enjoyed 25 years of life that would have been taken from her if she had not been talked out of pursuing assisted suicide under Oregon's fatally flawed law.

3. Unable to Access Effective Treatment

Medicine is a very broad field with new treatments being developed all the time and new studies providing updated evidence on "likely outcomes" of known treatments.

Out of the four deaths under the Northern Territory's euthanasia law there is evidence that two of the people (50%) put to death could have benefited from medical treatment which they did not receive.

In case 3 the patient may have benefited from radiotherapy or strontium but neither of these was available in the Northern Territory.[16]

In case 5, the patient had an obstruction and was clinically jaundiced.[17] The ROTI Act required Dr Nitschke as a "*medical practitioner who receives a request*" to have "*informed the patient of the nature of the illness and its likely course, and the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures for*

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[15] Kenneth Stevens "Doctor helped patient with cancer choose life over assisted suicide", *Missoulian,* 27 November 2012, http://missoulian.com/news/opinion/mailbag/doctor-helped-patient-with-cancer-choose-life-over-assisted-suicide/article_63e092dc-37e5-11e2-ae61-001a4bcf887a.html

[16] Kissane, D W, Street, A, Nitchske, P, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia", *The Lancet*, Vol 352, 3 October 1998, p 1099.

[17] Ibid., p 1100.

keeping the patient alive, that might be available to the patient."[18] However, Kissane reports that "*when questioned about options like stenting for obstructive jaundice or the management of bowel obstruction*" Dr Nitschke "*acknowledged limited experience, not having been involved in the care for the dying before becoming involved with the ROTI Act*."[19]

This raises doubts as to whether the patient in this case – who was reported by Dr Nitschke to exhibit "*indecisiveness*" over a two-month period about whether or not to request euthanasia – would still have done so if he had been given better symptomatic relief for the jaundice and obstruction.[20]

A study of 45 people euthanased at Ottawa Hospital for lung cancer showed that in 13 cases there was no confirmation of the condition by biopsy - a standard diagnostic procedure. In 10 cases there was no consultation with a medical oncologist. The time between diagnosis and euthanasia being performed was as short as 3 weeks.[21]

Treatments for lung cancer have improved considerably over the last few years leading to a reduction in mortality and an increase in the five year survival rate which is now 21.7%, according to the (US) National Cancer Institute.[22]

Any scheme that legalises assistance to suicide or euthanasia will result in the wrongful deaths of people who miss out on effective treatment that could have given them further years of life.

4. No access to palliative care

No case for legalising assisted suicide can properly be made on the basis that this is the only possible response to people facing unrelievable pain. Every person in the Australian Capital Territory deserves access to gold standard palliative care which can alleviate pain, including using palliative sedation as a last resort.

The Australian Pain Management Association has warned legalising euthanasia "*may lead to government having an opportunity for people to end their life with the help of another person*

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[18] *Rights of the Terminally Ill Act 1995*, Section 7(1)(e).

[19] Kissane, D W, Street, A, Nitchske, P, op. cit., p 1101

[20] Ibid., p 1100.

[21] Moore S, Thabet C, Wheatley-Price P. Brief Report: Medical Assistance in Dying in Patients With Lung Cancer. JTO Clin Res Rep. 2022 Jan 21;3(2):10028, https://www.sciencedirect.com/science/article/pii/S266636432200008X

[22] https://seer.cancer.gov/statfacts/html/lungb.html

rather than investing in early pain management support and the medical treatment and community support that people need in order to have a 'good death' and die with dignity".[23]

Section 4 of the ROTI Act provided that: "*A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient's medical practitioner to assist the patient to terminate the patient's life*."

Section 7(1)(d) provided that "*a medical practitioner may assist a patient to end his or her life*" only if, among other conditions, "*the illness is causing the patient severe pain or suffering*".

Section 8 of the ROTI Act provided that a "*medical practitioner shall not assist a patient under this Act if, in his or her opinion, and after considering the advice of the medical practitioner*" who has the "*prescribed qualifications, or has prescribed experience, in the treatment of the terminal illness from which the patient is suffering*" (cf Section 7(1)(c)(i)), "*there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient*."

Kissane reports that pain "*was not a prominent clinical issue in our study*"[24]. In case 3, "*the patient took morphine for generalised bone pain*."[25] For case 4, "*pain was well controlled*".[26] In case 5 the patient "*complained of mild background pain incompletely relieved by medication*".[27] In case 6, "*regular analgesia was needed for abdominal pain*".[28]

In none of these four cases is there any evidence of severe pain that was not being adequately controlled.

Other kinds of suffering or distress are reported. In case 3, these included "*intermittent nausea, constipation, and diarrhoea*" and "*catheterisation*"[29]. In case 4 the dominant problem was "*pruritus*".[30] In case 5 there were symptoms associated with the obstructive jaundice, which seems to have been inadequately treated. In case 6 a key factor seemed to

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[23] https://www.painmanagement.org.au/

[24] Ibid., p 1102.

[25] Ibid., p 1099.

[26] Ibid., p 1099.

[27] Ibid., p 1100.

[28] Ibid.

[29] Ibid., p. 1099.

[30] Ibid.

be patient's distress at "*having witnessed*" the death of her sister who also had breast cancer, "*particularly the indignity of double incontinence*".[31] She "*feared she would die in a similar manner*". She "*was also concerned about being a burden to her children, although her daughters were trained nurses*".

Kissane noted that "*fatigue, frailty, depression and other symptoms*" – not pain – were the prominent concerns of those who received euthanasia. He observed that "*palliative care facilities were underdeveloped in the Northern Territory, and patients in our study needed palliative care… There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care*."

Wrongful deaths occur when people are not fully informed about palliative care by specialists or cannot access adequate palliative care and then request euthanasia or assistance to suicide due to misplaced fears about pain or other physical symptoms.

5. Denied funding for medical treatment

People who are denied funding for medical treatment by medical insurers or the public health system but are offered funding for assisted suicide or euthanasia, as has happened in Oregon, California and Canada are at risk of wrongful deaths either by being denied needed treatment or bullied into agreeing to assisted suicide.

Roger Foley, who has a crippling brain disease, has been seeking support to live at home. He is currently in an Ontario hospital that is threatening to start charging him $1,800 a day. The hospital has told Roger that his other option is euthanasia under law.[32]

Of those who died from ingesting a lethal dose of medication in Oregon in 2021, more than one in twelve (8.4%) mentioned the "*financial implications of treatment*" as a consideration.[33]

Despite Medicare and public hospitals there are still cases where people cannot easily afford some effective life-saving medical treatments in the Northern Territory. No scheme legalising euthanasia or assistance to suicide can guarantee against wrongful deaths from a cheap Territory-funded prescribed lethal substance as an alternative to a more expensive life-saving treatment being accepted by vulnerable people.

VULNERABLE PEOPLE AT PARTICULAR RISK

Demand for legalising assistance to suicide and euthanasia, under the euphemistic phrase "voluntary assisted dying", is driven by a narrow, naïve and optimistic view of "autonomy"

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[31] Ibid. p 1100.

[32] https://www.australiancarealliance.org.au/canada_assisted_suicide_not_assisted_living

[33] Oregon Public Health Division, *Oregon Death With Dignity Act: 2018 Data Summary, Table 1,* p.12 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

that fails to take account of the impacts of mental illness, disability and elder abuse on vulnerable people's ability to fully exercise their self-determination. In a society that fails to value the vulnerable and reflects ingrained prejudices against those with mental illness, disability or the frailties and challenges of old age, vulnerable people can internalise these prejudices and be made to feel that others would be better off without them, and they themselves would be "better off dead".

The "tick-a-box" assessments of decision-making capacity and voluntariness required by each of the existing "voluntary assisted dying" schemes in Australia simply fail to address the complexities of these social and personal situations for vulnerable people. Any such scheme poses a real threat to the lives of the mentally ill, disabled and elderly.

6. Mentally ill at risk of wrongful death

People with a mental illness are at risk of wrongful death even where mental illness itself is not seen as a condition justifying euthanasia.

Linda Ganzini reported that one in six people who died under Oregon's law had clinical depression.[34] Depression is supposed to be screened for under the law. In 2021 only two of 238 people who died under the law were referred for a psychiatric evaluation before being given a lethal substance.[35] Over the 24 years of legalisation about 289 people with clinical depression have died by prescribed lethal poison without being referred for a psychiatric evaluation.

Dr. Charles J. Bentz reported on a 76-year-old patient he referred to a cancer specialist. The patient was a keen hiker and as he underwent therapy, he became depressed partly because he was less able to engage in hiking and expressed a wish for assisted suicide to the cancer specialist, who rather than making any effort to deal with the patient's depression, proceeded to act on this request by asking Dr Bentz to be the second concurring physician.

When Dr Bentz declined and proposed that the patient's depression should be addressed the cancer specialist found a more compliant doctor for a second opinion and two weeks later the patient was dead from a prescribed lethal overdose.

Dr Bentz concludes:

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[34] Linda Ganzini et al., "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey", *BMJ* 2008;337:a1682, http://www.bmj.com/content/bmj/337/bmj.a1682.full.pdf

[35] Oregon Public Health Division, *Oregon Death With Dignity Act: 2021 Data Summary, Table 1,* p.12, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf

> *In most jurisdictions, suicidal ideation is interpreted as a cry for help. In Oregon, the only help my patient got was a lethal prescription intended to kill him.*" [36]

The ROTI Act provided that euthanasia could not take place until "*a qualified psychiatrist*" has "*confirmed that the patient is not suffering from a treatable clinical depression in respect of the illness*" (Section 7(1)(c)(ii) and (iv)).

David Kissane has reported on how ineffective this provision – one of the strictest ever included in "voluntary assisted dying" legislation, failed to protect vulnerable people with depression and demoralisation associated with serious illness.[37]

In case 3, the patient had received "*counselling and anti-depressant medication for several years*". He spoke of feeling sometimes so suicidal that "*if he had a gun he would have used it*". He had outbursts in which he would "*yell and scream, as intolerant as hell*" and he "*wept frequently*".

Neither the patient's adult sons nor the members of the community palliative care team who were caring for him were told he was being assessed for euthanasia. "*A psychiatrist from another state certified that no treatable clinical depression was present*."

In case 4, "*the psychiatrist noted that the patient showed reduced reactivity to her surroundings, lowered mood, hopelessness, resignation about her future, and a desire to die. He judged her depression consistent with her medical condition, adding that side-effects of her antidepressant medication, dozepin, may limit further increase in dose*."

Kissane comments that "*case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management*." While Dr Nitschke "*judged this patient as unlikely to respond to further treatment*", Kissane, comments that "*nonetheless, continued psychiatric care seemed warranted – a psychiatrist can have an active therapeutic role in ameliorating suffering rather than being used only as a gatekeeper to euthanasia*".

Further concerns are raised by the report on case 5. Dr Nitschke reported that "*on this occasion the psychiatrist phoned within 20 min, saying that this case was straightforward*". This assessment took place on the day on which euthanasia was planned. This case involved an elderly, unmarried man who had migrated from England and had no relatives in Australia. Dr Nitschke recalled "*his sadness over the man's loneliness and isolation as he administered euthanasia*". Dr Nitschke has since revealed in testimony to a Senate

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[36] http://blogs.theprovince.com/2011/12/05/province-letters-icbc-egypt-assisted-suicide-oregon-christmas-pre-marital-sex/

[37] Kissane, D W, Street, A, Nitchske, P, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia", *The Lancet*, Vol 352, 3 October 1998, p 1097-1102.

committee, that he personally paid for this psychiatric consultation and that it in fact took less than 20 minutes.[38]

Dr David Kissane, comments on the issue of demoralisation:

> *Review of these patients' stories highlighted for me the importance of demoralization as a significant mental state influencing the choices these patients made. They described the pointlessness of their lives, a loss of any worthwhile hope and meaning.*
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> *Their thoughts followed a typical pattern of thinking that appeared to be based on pessimism, sometimes exaggeration of their circumstances, all-or-nothing thinking in which only extremes could be thought about, negative self-labelling and they perceived themselves to be trapped in this predicament. Often socially isolated, their hopelessness led to a desire to die, sometimes as a harbinger of depression, but not always with development of a clinical depressive disorder. It is likely that the mental state of demoralization influenced their judgement, narrowing their perspective of available options and choices. Furthermore, demoralized patients may not make a truly informed decision in giving medical consent.*
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> *Demoralization syndrome … is an important diagnosis to be made and actively treated during advanced cancer. It is recognised by the core phenomenology of hopelessness or meaninglessness about life. The prognostic language within oncology that designates 'there is no cure' is one potential cause of demoralization in these patients, a cause that can be avoided by more sensitive medical communication with the seriously ill. While truth telling is needed, hope must also be sustained so that life may be lived out as fully as possible. Patients with advanced cancer can be guided to focus on 'being' rather than 'doing', savouring the experiential moment of the present, so that purpose and meaning are preserved through inherent regard for the dignity of the person. Active treatment of a demoralized state by hospice services would involve counselling and a range of complementary therapies, use of community volunteers and family supports, all designed to counter isolation and restore meaning*.[39]

While Australian "voluntary assisted dying" laws generally exclude euthanasia or assistance to suicide solely on the basis of a mental illness or mental disorder, they

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[38] Nitschke, P., *Hansard,* Senate Standing Committee on Legal and Constitutional Affairs, Reference: *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008,* Monday, 14 April 2008, Darwin, p 42; https://www.aph.gov.au/~/media/wopapub/senate/senate/commttee/S10740_pdf.ashx

[39] Kissane DW., "Deadly days in Darwin" in *The Case Against Assisted Suicide*, K. Foley & H. Hendin (ed), Johns Hopkins University Press, 2002, p.192-209 Available at: https://www.aph.gov.au/~/media/wopapub/senate/committee/legcon_ctte/completed_inquiries/2008_10/terminally_ill/submissions/sub589_pdf.ashx

nonetheless lack safeguards to adequately identify depression or other mental illness that may be treatable and may be unduly affecting a person’s decision-making capacity.

7. Better off dead than disabled

Due to widespread social prejudice people with disabilities are often considered to be “*better off dead*”. This puts them at additional risk of wrongful death under any scheme that legalises euthanasia.

In Oregon the **five main reasons** given for requesting assisted suicide **all relate to disability** issues: concerns about decreasing ability to participate in activities that made life enjoyable, loss of autonomy, loss of dignity, physical or emotional burden on family, friends, or caregivers and loss of control of bodily functions, such as incontinence.[40]

The late Stella Young, comedian and disability activist, wrote:

People make all sorts of assumptions about the quality of my life and my levels of independence. They're almost always wrong.

*I've lost count of the number of times I've been told, "I just don't think I could live like you," or "I wouldn't have the courage in your situation," or, **my favourite one to overhear (and I've overheard it more than once), "You'd just bloody top yourself, wouldn't you?"**.*

As a disabled person who has had a lot to do with the medical profession, I can tell you that this is the space in which I've experienced some of the very worst disability prejudice and discrimination.

ABC News reported on a woman with motor neurone disease who said " I can use my left hand, my right hand is just about useless. If I can't use my left hand to wipe my bottom, then I can do nothing else for myself. That means someone has to do everything for me. I couldn't bear to live like that."

*The thing is a lot of people do live like that. I know many, many people who depend on personal assistants for all of their daily living tasks, some of them requiring 24-hour care. **Having to rely on someone else to wipe your bum may not be something anyone aspires to, but I'm quite sure it's never killed anyone.*** [41]

While Australian “voluntary assisted dying” laws generally exclude euthanasia or assistance to suicide solely on the basis of a disability, it puts people with a disability at greater risk of wrongful death due to the ableist attitudes in society, and among health practitioners, identified by Stella Young and other disability activists.

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[40] https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf

[41] http://www.abc.net.au/rampup/articles/2013/10/18/3872088.htm

8. Bullying and Coercion

Dr Henry Marsh, a British neurosurgeon and proponent of legalising assisted suicide has acknowledged the possibility of coercion leading to wrongful deaths under such a law but he simply doesn't care:

> *"Even if a few grannies get bullied into [suicide], isn't that the price worth paying for all the people who could die with dignity?"* [42]

Under Victoria's *Voluntary Assisted Dying Act 2017,* assessing doctors are required to complete training approved by the Secretary of the Department of Health and Human Services on "*identifying and assessing risk factors for abuse or coercion*".

The section in the prescribed training which doctors must undergo before participating as assessing or consulting doctors that covers assessing voluntariness, including assessing the absence of coercion, totals just over 5 minutes, including a 2 minute 20 second video and slides which take a further 2 minutes 50 seconds to read. This obviously cannot guarantee that assessing doctors never miss the signs of coercion or abuse given the well-documented evidence of failure by professionals in Australia to identify elder abuse.[43]

A report on elder abuse in Australia[44] illustrates the environment in which legalised euthanasia poses a real risk the vulnerable elderly.

The estimate for the prevalence of elder abuse among community dwelling people aged 65 and older in Australia is ***14.8% …*** *The most common form of abuse is psychological abuse (11.7%). Neglect is the next most common abuse subtype at 2.9%. For the other subtypes, prevalence rates are 2.1% for financial abuse, 1.8% for physical abuse and 1% for sexual abuse.*

Proponents of euthanasia who dismiss the risk of elder abuse are naïve, disingenuous or callously focused on demanding their "right to die" at any cost.

Adult children were most likely to commit financial, physical, and psychological abuse. Adult children were on par with intimate partners as perpetrators of neglect. Intimate partners also featured commonly as perpetrators of physical, psychological, and sexual abuse.

… [many] perpetrators were reported to have financial problems (nearly one in five).

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[42] https://www.medscape.com/viewarticle/879187

[43] https://www.australiancarealliance.org.au/bullying_or_coercion

[44] Qu, L. et al. *National Elder Abuse Prevalence Study: Final Report,* Dec 2021, https://aifs.gov.au/publications/national-elder-abuse-prevalence-study-final-report

*Inheritance impatience was a characteristic of 19.1% of abusers in Queensland in 2018/19***.**

Elderly people supplied with a lethal poison may be at risk from adult children and intimate partners perpetrating financial, physical and psychological abuse – including seeking to hasten the death of the person for financial benefit by bullying, nagging or persuading the person to ingest the poison or even physically forcing the person to ingest it.

There is ***a correlation between all abuse subtypes and low social support*** *(including social isolation and loneliness). A low sense of social support is the highest risk factor for physical abuse (30.4%) and the second highest risk factor for financial abuse (29.8%).*

There is also a correlation between isolation and loneliness and requests for euthanasia.

The report for Quebec for 2021/22, stated 824 (23%) of people reported "*isolation or loneliness*" as a reason for wishing to have their life ended by a lethal injection.

Where older people sought professional help, they were more likely to turn to the helping professions such as GPs and nurses … of those older people who reported taking action, ***substantial minorities considered these actions were ineffective****.* ***Responses indicating actions were ineffective were highest for financial abuse (over one third)***

There is no guarantee that medical practitioners assessing people for access to euthanasia will identify or respond to the risk of financial, psychological or physical abuse playing a role in a person's request for a lethal poison to end their life.

Without an independent witness required to be present at the time of alleged self-administration we simply cannot be sure that the lethal poison was not surreptitiously or even forcibly administered to a person. **Bald claims that there is no evidence of such abuse are of no evidential value**.

Elder lawyer, Margaret Dore, cites the case of Tami Sawyer, trustee for Thomas Middleton in Oregon. Two days after his death by assisted suicide, she sold his home and deposited the proceeds into bank accounts for her own benefit.[45]

Having financially defrauded Middleton by subtle persuasion it is possible that Sawyer also persuaded or tricked him into taking the poison. But Oregon authorities declined to investigate this possibility.

In Victoria, on 14 August 2023, Dr. Nick Carr was found to have acted unprofessionally under Vctoria's Voluntary Assisted Dying Act 2017 by failing to get the required two people to actually witness an applicant sign the final request form. One of the claimed safeguards in Victoria to supposedly ensure that a request is voluntary is to require tow independent witnesses to sign the "final request form" stating that they witnessed the applicant voluntarily signing the form.

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[45] https://choiceisanillusion.files.wordpress.com/2019/12/amicus-sawyer-arraigned.pdf noel

Well, Dr Nick Carr got the witnesses to sign the form but failed to get the person to sign the form. Why were they signing that they saw the applicant sign the form when the applicant didn't sign the form? What did they think they were doing? Just signing were the doctor told them to sign?

After Dr Carr submitted the application form a diligent clerk at the Voluntary Assisted Dying Review Board actually noticed that the applicant's signature was missing. However when it was sent back to Dr Carr he simply got the applicant to sign te form, leaving the previous "witness" signatures in place.

This application, which still lacked the required signatures of two persons actually witnessing the applicant "voluntarily" sign the form was (wrongly) approved by the Secretary for Health and Human Services and a permit to prescribe and administer a lethal substance to cause the person's death was issued.

While Dr Carr was found to gave acted unprofessionally and fined, no action seems to have been taken against the Secretary for issuing a permit to cause the death of a person without the required evidence that the person voluntarily requested this death.

All Australian "voluntary assisted dying" laws rely on the assessing health practitioners identifying coercion. The evidence, set out above, is that doctors miss evidence of coercion, and even fudge alleged safeguards, leaving the abused at risk.

9. Social contagion of suicide

Legalising assistance to suicide for some people in the Northern Territory would undermine the commitment to **suicide prevention for all** by affirming that such people would be better off dead and supporting their suicide as a rational choice to be facilitated rather than prevented.

People diagnosed with a terminal illness are at greatest risk of suicide within the first six months of diagnosis and often miss out on accurate diagnosis of depression and anxiety for which effective treatments are available.[46]

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[46] Nafilyan V, et al., "Risk of suicide after diagnosis of severe physical health conditions: a retrospective cohort study of 47 million people", *The Lancet Regional Health - Europe* 2023;25: 100562, Published Online 14 December 2022, https://www.thelancet.com/action/showPdf?pii=S2666-7762%2822%2900258-7 ; Fulton JJ, et al., "Psychotherapy targeting depression and anxiety for use in palliative care: a meta-analysis*", Journal of Palliative Medicine,* Jul 2018, Vol. 21: 1024-1037*,* https://www.liebertpub.com/doi/10.1089/jpm.2017.0576 ; Schweighoffer R. et al., "A systematic review and bayesian network meta-analysis investigating the effectiveness of psychological short-term interventions in inpatient palliative care settings.", *Int J Environ Res Public Health*, 2022;19, https://www.mdpi.com/1660-4601/19/13/7711/pdf

A study of US data comparing States which had legalised assisted suicide with those which have not has shown that legalising assisted suicide is associated with an increase in the overall rate of suicides of 6.5% and of the elderly (65 years and older) by 14.5%.[47]

This conclusion is supported by **evidence from Victoria**.

When arguing for the legalisation of assistance to suicide, then Minister for Health and Human Services, the Hon Jill Hennessy, claimed:
Evidence from the coroner indicated that one terminally ill Victorian was taking their life each week.[48] She argued legalisation would prevent these 50 suicides each year.

Not only has there been no such decline, but there were 62 more suicides in Victoria in 2022 than in 2017, when this claim was made. The suicide rate among those aged over 65 years increased from 2019 to 2022 by 42 per cent in Victoria, where "voluntary assisted dying" was legal—five times the increase over the same period in New South Wales where it remained illegal.[49]

Legalising assistance to suicide and euthanasia would be contrary to the Northern Territory's Suicide Prevention Implementation Plan 2023-28.[50] This plan specifically identifies "chronic pain or illness" as a risk factor for suicide, as well as several factors that are regularly listed as motivations for requesting euthanasia such as "little sense of control over life circumstances"; "lack of meaning and purpose in life"; "immobility"; "hopelessness"; "social isolation"; and "lack of support services".

It makes no sense to consider these risk factors for suicide demanding a protective response to prevent suicide and at the same time treat them as a reason to facilitate a government-approved "suicide-by-doctor".

Australian State laws on "voluntary assisted dying" attempt to exclude the intentional causing of a person's death by self- or practitioner-administration of a lethal substance from the category of suicide. The recent decision by the Federal Court in *Carr v Attorney-General (Cth) [2023] FCA 1500* gave short shrift to this attempt at changing the reality of these acts by juggling with words by formally declaring:

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[47] Jones, David A and D. Paton. "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?" *Southern Medical Journal* 108 (2015): 599–604, https://nottingham-repository.worktribe.com/OutputFile/981911

[48] https://www.parliament.vic.gov.au/images/stories/daily-hansard/Assembly_2017/Assembly_Daily_Extract_Thursday_21_September_2017_from_Book_12.pdf

[49] https://jemh.ca/issues/open/documents/Did%20the%20Voluntary%20Assisted%20Dying%20Act%202017.pdf

[50] https://health.nt.gov.au/__data/assets/pdf_file/0009/1275930/northern-territory-suicide-prevention-implementation-plan-2023-28.PDF

> *The term "suicide" … does apply to the ending of a person's life in accordance with, and by the means authorised by, the* Voluntary Assisted Dying Act 2017 *(Vic) and* Voluntary Assisted Dying Regulations 2018 *(Vic).*[51]

Legalising euthanasia and assistance to suicide in the Northern Territory will not prevent suicide and is likely to lead to an increase in the suicide rate.

10. Killed without request or while resisting

In the Netherlands in 2015 there were 431 cases of euthanasia without explicit request, representing 6.06% of all euthanasia deaths.[52] It appears that making it lawful for doctors to directly kill their patients in certain specified circumstances leads to some of those doctors feeling empowered to directly take the lives of other patients outside the legal framework.

It should never be forgotten that the Northern Territory's *Right of the Terminally Ill Act* gave Philip Nitschke the initial experience of ending the lives of four people before he went on to found the international death cult Exit International, which facilitates suicide without any requirement for any illness at all or any safeguards to protect the mentally ill or coerced.

The Dutch Supreme Court has affirmed that the forcible euthanasia of a person verbally and actively resisting being killed can be legally justified based on a valid advanced directive requesting euthanasia. [53]

11. Lacking decision-making capacity

A study of decision-making capacity of persons with terminal cancer and a prognosis of less than six months to live[54] found 90% impaired in regard to at least one of the four elements of decision making – Choice (15%), Understanding (44%), Appreciation (49%) and Reasoning (85%).

The study also found a significant discrepancy between physician assessments of decision-making capacity compared to the actual decision-making capacity as tested on the MacCAT-T scales. **Physicians assessed as "unimpaired" 100% of those who had impaired Choice**.

This lack of ability of physicians who are actively caring for terminally ill cancer patients to accurately assess their patients' decision-making capacity is likely to be worse in doctors who do not have an established relationship with the person before assessing a request for assisted suicide, which is often the usual case under schemes for "voluntary assisted dying".

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[51] https://www.judgments.fedcourt.gov.au/judgments/Judgments/fca/single/2023/2023fca1500

[52] https://opendata.cbs.nl/statline/#/CBS/en/dataset/81655ENG/table?ts=1525401083207

[53] https://www.theguardian.com/world/2020/apr/21/dutch-court-approves-euthanasia-in-cases-of-advanced-dementia

[54] Elissa Kolva et al., "Assessing the decision making capacity of terminally ill patients with cancer", American Journal of Geriatric Psychiatry, 2018 May; 26(5): 523–531, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6345171/pdf/nihms937741.pdf

NO GUARANTEE OF A RAPID, PEACEFUL DEATH

12. Inhumane Deaths by Assisted Suicide and Euthanasia

The case for legalising assistance to suicide and euthanasia **assumes** that all such deaths will be rapid and peaceful. This is not the case. An article in the journal *Anaesthesia* found:

Complications related to assisted dying methods were found to include difficulty in swallowing the prescribed dose (≤9%), a relatively high incidence of vomiting (≤10%), prolongation of death (by as much as seven days in ≤4%), and failure to induce coma, where patients re-awoke and even sat up (≤1.3%).

This raises a concern that some deaths may be inhumane.[55]

Many of the lethal poisons, such as sodium pentobarbital, used for capital punishment in the United States are also used for euthanasia and assisted suicide.

David Waisel, an anaesthesiologist, has testified about the use of this drug in executions.

Based on his lurching toward his arms and the lifting of his head and the mouthing of words, I can say with certainty that Mr. Blankenship was inadequately anesthetized and was conscious for approximately the first three minutes of the execution and that he suffered greatly. Mr. Blankenship should not have been conscious or exhibiting these movements, nor should his eyes have been open, after the injection of pentobarbital.

… Mr. Blankenship's execution further evidences that ***during judicial lethal injections in Georgia there is a substantial risk of serious harm such that condemned inmates are significantly likely to face extreme, torturous and needless pain and suffering***.[56]

A 2020 review, published by NPR, of 216 autopsies conducted after execution in US States by lethal injection found signs of pulmonary oedema in 84% of the cases. The findings were similar across the states and, notably, across the different drug protocols used.[57]

Anaesthetist Dr Zivot comments that "*without a general anaesthetic, many will be in great discomfort, even if outwardly they don't appear to be suffering*."

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[55] https://assets.nationbuilder.com/australiancarealliance/pages/139/attachments/original/1551911256/Sinmyee_et_al-2019-Anaesthesia.pdf?1551911256

[56] State of Massachussetts, County of Suffolk., *Affidavit of David B. Waisel, MD*, p. 2-3

[57] https://www.npr.org/2020/09/21/793177589/gasping-for-air-autopsies-reveal-troubling-effects-of-lethal-injection

APPENDIX B: AN ANALYSIS OF THE OPERATION OF THE NORTHERN TERRITORY'S RIGHTS OF THE TERMINALLY ILL ACT FROM 1 JULY 1996 TO 27 MARCH 1997

The *Rights of the Terminally Ill Act 1995* (the ROTI Act) was in operation in the Northern Territory from 1 July 1996 until it was suppressed by the Commonwealth's *Euthanasia Laws Act 1997* on 27 March 1997.

During the nine-month period in which the ROTI Act was in effect and under its provisions, four people were assisted to terminate their lives by Dr Philip Nitschke.

Case studies on these four deaths have been published.[58] The principal author of this paper is Professor David Kissane, who is a consultant psychiatrist and professor of palliative medicine. Philip Nitschke is a co-author of the paper.

The case studies examine how the conditions required by the ROTI Act were met. Cases numbered 3, 4, 5 and 6 in this paper refer to those cases which ended with the person's life being terminated with the assistance of Dr Philip Nitschke.

Clinical depression or demoralisation

Kissane noted that "*fatigue, frailty, depression and other symptoms*" – not pain – were the prominent concerns of those who received euthanasia. He observed that "*palliative care facilities were underdeveloped in the Northern Territory, and patients in our study needed palliative care… There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care*."

From the case histories, it is apparent that cases 3 and 4 each had depressive symptoms.

In case 3, the patient had received "*counselling and anti-depressant medication for several years*". He spoke of feeling sometimes so suicidal that "*if he had a gun he would have used it*". He had outbursts in which he would "*yell and scream, as intolerant as hell*" and he "*wept frequently*".

Neither the patient's adult sons nor the members of the community palliative care team who were caring for him were told he was being assessed for euthanasia. "*A psychiatrist from another state certified that no treatable clinical depression was present*."

In case 4, "*the psychiatrist noted that the patient showed reduced reactivity to her surroundings, lowered mood, hopelessness, resignation about her future, and a desire to die. He judged her depression consistent with her medical condition, adding that side-effects of her antidepressant medication, dozepin, may limit further increase in dose*."

Kissane comments that "*case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management*." While Dr Nitschke "*judged this patient as unlikely to respond to further treatment*", Kissane, comments that "*nonetheless, continued psychiatric care seemed warranted – a psychiatrist can have an active*

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[58] Kissane, D W, Street, A, Nitchske, P, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia", *The Lancet*, Vol 352, 3 October 1998, p 1097-1102.

therapeutic role in ameliorating suffering rather than being used only as a gatekeeper to euthanasia".

Further concerns are raised by the report on case 5. Dr Nitschke reported that "*on this occasion the psychiatrist phoned within 20 min, saying that this case was straightforward*". This assessment took place on the day on which euthanasia was planned. This case involved an elderly, unmarried man who had migrated from England and had no relatives in Australia. Dr Nitschke recalled "*his sadness over the man's loneliness and isolation as he administered euthanasia*". Dr Nitschke has since revealed in testimony to a Senate committee, that he personally paid for this psychiatric consultation and that it in fact took less than 20 minutes.[59]

Dr David Kissane, comments on the issue of demoralisation:

> *Review of these patients' stories highlighted for me the importance of demoralization as a significant mental state influencing the choices these patients made. They described the pointlessness of their lives, a loss of any worthwhile hope and meaning.*
>
> *Their thoughts followed a typical pattern of thinking that appeared to be based on pessimism, sometimes exaggeration of their circumstances, all-or-nothing thinking in which only extremes could be thought about, negative self-labelling and they perceived themselves to be trapped in this predicament. Often socially isolated, their hopelessness led to a desire to die, sometimes as a harbinger of depression, but not always with development of a clinical depressive disorder. It is likely that the mental state of demoralization influenced their judgement, narrowing their perspective of available options and choices. Furthermore, demoralized patients may not make a truly informed decision in giving medical consent.*
>
> *Demoralization syndrome … is an important diagnosis to be made and actively treated during advanced cancer. It is recognised by the core phenomenology of hopelessness or meaninglessness about life. The prognostic language within oncology that designates 'there is no cure' is one potential cause of demoralization in these patients, a cause that can be avoided by more sensitive medical communication with the seriously ill. While truth telling is needed, hope must also be sustained so that life may be lived out as fully as possible. Patients with advanced cancer can be guided to focus on 'being' rather than 'doing', savouring the experiential moment of the present, so that purpose and meaning are preserved through inherent regard for the dignity of the person. Active treatment of a demoralized state by hospice services would involve counselling and a range of complementary therapies, use of community volunteers and family supports, all designed to counter isolation and restore meaning.*[60]

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[59] Nitschke, P., *Hansard,* Senate Standing Committee on Legal and Constitutional Affairs, Reference: *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008,* Monday, 14 April 2008, Darwin, p 42; https://www.aph.gov.au/~/media/wopapub/senate/senate/commttee/S10740_pdf.ashx

[60] Kissane DW., "Deadly days in Darwin" in *The Case Against Assisted Suicide*, K. Foley & H. Hendin (ed), Johns Hopkins University Press, 2002, p.192-209 Available at:

Terminal illness?

The ROTI Act provided (Section 4) that: *"A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient's medical practitioner to assist the patient to terminate the patient's life*."

The ROTI Act (Section 3) defined that: "*'terminal illness', in relation to a patient, means an illness which, in reasonable medical judgment will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient*."

The ROTI Act further provided that a "*medical practitioner who receives a request*" may, if certain conditions are met, "*assist the patient to terminate the patient's life*".

The conditions to be met included that:

- "*the medical practitioner is satisfied, on reasonable grounds, that – (i) the patient is suffering from an illness that will, in the normal course and without the application of extraordinary measures, result in the death of the patient; (ii) in reasonable medical judgment, there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure; and (iii) any medical treatment reasonably available to the patient is confined to the relief of pain, suffering and/or distress with the object of allowing the patient to die a comfortable death*;" (Section 7(1)(b));
- a second "*medical practitioner who holds prescribed qualifications, or has prescribed experience, in the treatment of the terminal illness from which the patient is suffering*" has examined the patient and has confirmed *"(A) the first medical practitioner's opinion as to the existence and seriousness of the illness; (B) that the patient is likely to die as a result of the illness; and (C) the first medical practitioner's prognosis*" (Section 7(1)(c)(i) and (iii));
- "*a qualified psychiatrist*" has "*confirmed that the patient is not suffering from a treatable clinical depression in respect of the illness*" (Section 7(1)(c)(ii) and (iv)); and
- the illness is causing the patient severe pain or suffering (Section 7(1)(d))

In case 4, there was no consensus that the person was terminally ill. The person was diagnosed with mycosis fungoides. "*One oncologist gave the patient's prognosis as 9 months, but a dermatologist and a local oncologist judged that she was not terminally ill. Other practitioners declined to give an opinion. In the end an orthopaedic surgeon certified that the ROTI provisions for terminal illness had been complied with*."[61]

In case 3 the patient may have benefited from radiotherapy or strontium but neither of these was available in the Northern Territory.[62]

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https://www.aph.gov.au/~/media/wopapub/senate/committee/legcon_ctte/completed_inquiries/2008_10/terminally_ill/submissions/sub589_pdf.ashx

[61] Kissane, D W, Street, A, Nitchske, P, op. cit., p 1101.

[62] Ibid., p 1099.

In case 5, the patient had an obstruction and was clinically jaundiced.[63] The ROTI Act required Dr Nitschke as a "*medical practitioner who receives a request*" to have "*informed the patient of the nature of the illness and its likely course, and the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures for keeping the patient alive, that might be available to the patient*."[64] However, Kissane reports that "*when questioned about options like stenting for obstructive jaundice or the management of bowel obstruction*" Dr Nitschke "*acknowledged limited experience, not having been involved in the care for the dying before becoming involved with the ROTI Act*."[65]

This raises doubts as to whether the patient in this case – who was reported by Dr Nitschke to exhibit "*indecisiveness*" over a two month period about whether or not to request euthanasia – would still have done so if he had been given better symptomatic relief for the jaundice and obstruction.[66]

Severe Pain Not the Issue

Section 4 of the ROTI Act provided that: "*A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient's medical practitioner to assist the patient to terminate the patient's life*."

Section 7(1)(d) provided that "*a medical practitioner may assist a patient to end his or her life*" only if, among other conditions, "*the illness is causing the patient severe pain or suffering*".

Section 8 of the ROTI Act provided that a "*medical practitioner shall not assist a patient under this Act if, in his or her opinion, and after considering the advice of the medical practitioner*" who has the "*prescribed qualifications, or has prescribed experience, in the treatment of the terminal illness from which the patient is suffering*" (cf Section 7(1)(c)(i)), "*there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient*."

Kissane reports that pain "*was not a prominent clinical issue in our study*"[67]. In case 3, "*the patient took morphine for generalised bone pain*."[68] For case 4, "*pain was well controlled*".[69] In case 5 the

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[63] Ibid., p 1100.

[64] *Rights of the Terminally Ill Act 1995*, Section 7(1)(e).

[65] Kissane, D W, Street, A, Nitchske, P, op. cit., p 1101

[66] Ibid., p 1100.

[67] Ibid., p 1102.

[68] Ibid., p 1099.

[69] Ibid., p 1099.

patient "*complained of mild background pain incompletely relieved by medication*".[70] In case 6, "*regular analgesia was needed for abdominal pain*".[71]

In none of these four cases is there any evidence of severe pain that was not being adequately controlled.

Other kinds of suffering or distress are reported. In case 3, these included "*intermittent nausea, constipation, and diarrhoea*" and "*catheterisation*"[72]. In case 4 the dominant problem was "*pruritus*".[73] In case 5 there were symptoms associated with the obstructive jaundice, which seems to have been inadequately treated. In case 6 a key factor seemed to be patient's distress at "*having witnessed*" the death of her sister who also had breast cancer, "*particularly the indignity of double incontinence*".[74] She "*feared she would die in a similar manner*". She "*was also concerned about being a burden to her children, although her daughters were trained nurses*".

Kissane noted that "*fatigue, frailty, depression and other symptoms*" – not pain – were the prominent concerns of those who received euthanasia. He observed that "*palliative care facilities were underdeveloped in the Northern Territory, and patients in our study needed palliative care… There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care*."

Conclusion

The failed experiment in the Northern Territory shows that apparently strict safeguards fail to ensure careful practice. It should not be repeated.

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[70] Ibid., p 1100.

[71] Ibid.

[72] Ibid., p. 1099.

[73] Ibid.

[74] Ibid. p 1100.