

Briefing Paper

on the

WA Voluntary Euthanasia Bill 2010

by

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TABLE OF CONTENTS

1. Introduction	1
2. Who may be killed by euthanasia?	1
3. No desire to continue living	2
4. Administration of euthanasia	4
5. Laws permitting euthanasia or physician assisted suicide in other jurisdictions	4
5.1 United Kingdom	5
5.2 Canada	5
5.3 United States	5
5.3.1 <i>New York Task Force on Life and the Law</i>	5
5.3.2 <i>Oregon</i>	7
5.4 The Netherlands	8
6. Australia	8
6.1 Northern Territory	8
6.1.1 <i>Terminal illness and further treatment options</i>	9
6.1.2 <i>“Severe Pain or Suffering”</i>	10
6.1.3 <i>No clinical depression</i>	10
6.1.4 <i>Senate Committee</i>	11
6.2 Other Australian states	11
7. Dr Phillip Nitschke	12
8. Conclusion and recommendation	12
9. Endnotes	13

1. Introduction

The *Voluntary Euthanasia Bill 2010* was introduced in the Western Australian Legislative Council on 20 May 2010 as a private member's bill by Hon Robin Chapple (Greens). The Bill would, if passed, legalise the intentional killing of certain persons by euthanasia in Western Australia.

2. Who may be killed by euthanasia?

The key test for whether or not a medical practitioner would be permitted to kill a person by euthanasia is set out in Subclause 6 (1) of the Bill, which would provide for a request for the administration of euthanasia to be made by:

A person who:

- (a) is of sound mind; and*
- (b) is aged 21 years or over; and*
- (c) is ordinarily resident in Western Australia and has been so ordinarily resident for the previous 3 consecutive years; and*
- (d) can communicate his or her intentions; and*
- (e) has a terminal illness; and*
- (f) is experiencing pain, suffering or debilitation that:*
 - (i) is considerable; and*
 - (ii) is related to the relevant terminal illness; and*
- (g) has no desire to continue living,*

may make a request for the administration of euthanasia by signing a request in the form set out in Part 1 of the Schedule whilst not in the presence of any near relative.

Clause 3 of the Bill defines “terminal illness” as follows:

***terminal illness** means a medically diagnosed illness or condition that will, in reasonable medical judgement, in the normal course and without application of extreme measures, result in the death of the applicant within 2 years of the date on which the request was made.*

The medical judgement that the diagnosed illness or condition will “*in the normal course and without application of extreme measures, result in the death of the applicant within 2 years*” would be made by any two medical practitioners.

The scheme of the Bill would allow “doctor shopping” so that if any medical practitioner approached to be the “second assessing medical practitioner” found that the various criteria – including the prognosis of death within 2 years – had not been met then there is no provision to have this finding recorded on the applicant’s medical record and nothing to prevent the applicant having recourse to further medical practitioners until one is found who will sign the relevant forms.

The terms “pain”, “suffering” and “debilitation” are not defined. “Suffering” is a very broad term which could readily be interpreted to include psychological or emotional distress. “Debilitation” simply means weakness or loss of energy.

The Bill would only require that one of these conditions – pain, suffering or debilitation – be experienced by the applicant, so that a person who is completely free of physical pain could still qualify for euthanasia on the grounds of “suffering”, possibly understood as emotional distress, or “debilitation”, that is weakness or loss of energy.

Clause 6(1) (f) (ii) does specify that the pain, suffering or debilitation must be “considerable”. This term is not defined in the bill. Its ordinary meaning is “worthy of consideration” in other words not negligible or trivial.

This is a very low threshold for allowing the direct killing of a person by euthanasia.

3. No desire to continue living

The Bill would require that an applicant be assessed by two medical practitioners as having “*no desire to continue living*” (Clause 6 (1) (g)).

It would also require that two medical practitioners declare that “*the applicant’s request is not wholly or substantially referable to, or wholly or substantially a symptom of, a state of clinical depression*” (Clause 9(2) (b)).

No psychiatric qualifications would be required to make this diagnosis of an absence of clinical depression and there would be no requirement that the applicant be referred to a psychiatrist.

Experience with Oregon’s *Death With Dignity Act* is instructive. Under that Act there is a provision for optional referral to a psychiatrist. Not surprisingly, referrals to psychiatrists have decreased since the Act came into effect. In 2007 not one patient out of 49 who applied for a lethal prescription was referred to a psychiatrist.

The Oregon Health Department has not allowed access to data for comprehensive studies on the effectiveness of this provision in avoiding the prescription of lethal medication to those with a history of depression, suicide or mental illness. However, a case study on one patient, Michael Freeland, has been presented at an *American Psychiatric Association Annual Meeting Symposium on Ethics and End-of-Life Care: New Insights and Challenges* in May 2004 by Gregory and Catherine Hamilton.¹

Although Mr Freeland had an extensive history of depression and suicidal ideation prior to his diagnosis with a terminal illness, he was given a prescription for lethal medication by Dr Peter Reagan, an assisted-suicide advocate who was associated with Compassion in Dying Federation. According to Mr Freeland’s daughter who accompanied him to an appointment, Dr Reagan commented that he did not think a psychiatric consultation would be necessary for Mr Freeland.

Fortunately Mr Freeland received support from other medical practitioners and from his daughter, so that he never took the lethal medication. He died peacefully some two years after first being prescribed it (even though Oregon law only allows prescription of lethal medication where death is likely within six months!).

The case study authors conclude:

“The legalization of doctor-assisted suicide in Oregon has resulted in the introduction of competing paradigms - the traditional clinical approach and the assisted-suicide competency model - for responding to suicidal thoughts and behaviors in seriously ill individuals. Careful

examination of events leading up to the death of the only case in which assisted-suicide drugs were legally prescribed for which medical records are available demonstrates that different models were used by some clinicians and others attempted to mix models, resulting in a confused and confusing approach to a life threatening symptom. These competing models appear to be based on incompatible underlying assumptions about the value of protecting human life depending on predictions of how long a patient might live, a prediction which cannot be made accurately. We conclude that the attempt to mix models is confusing to both clinicians and patients and endangers seriously ill patients, particularly those with a history of pre-existing mental illness.”

The difficulty of adequately identifying and protecting patients with underlying mental health issues applies to all proposals for legalised euthanasia.

The Bill fails to address this issue by leaving it entirely to the medical practitioner’s discretion whether to refer to a psychiatrist or not. Under the bill, such patients could receive euthanasia when in fact proper psychiatric treatment is warranted.

The Bill’s explicit criterion that an applicant has “*no desire to continue living*” is alarming. The lack of a desire to continue living would normally be taken as an indicator of clinical depression or of the demoralization that may accompany diagnosis of a terminal illness. It should be responded to with empathy and appropriate treatment not considered a positive criterion for being put to death by euthanasia.

After reviewing the operation of the Northern Territory’s Rights of the Terminally Ill Act, Dr David Kissane, who is Alfred P Sloan Chair, Attending Psychiatrist and Chairman of the Department of Psychiatry & Behavioral Sciences at Memorial Sloan-Kettering Cancer Center and Professor of Psychiatry, Weill Medical College of Cornell University, discusses 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. The third person to receive euthanasia in Darwin (name withheld) was an example of a demoralized patient, as also was Max Bell.

Demoralization syndrome has been considered, albeit briefly, in the consultation-liaison psychiatry literature and 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.²

4. Administration of euthanasia

Clause 11 (1) of the Bill would authorise the applicant's medical practitioner to "administer euthanasia to the applicant by administration of a recognised drug."

Clause 3 of the Bill defines "recognised drug" as follows:

recognised drug means a drug or drugs appropriate to administer euthanasia to a person, being those drugs prescribed by the regulations, in the quantities prescribed by the regulations, administered in the manner prescribed by the regulations;

It is profoundly disturbing to consider the implications of this provision. It would mean that the State of Western Australia in the person of the Governor, acting on the advice of his ministers, is to specify how certain Western Australians are to be effectively killed.

No such provisions have been in place in Western Australia since the death penalty was abolished in 1984 and there has never before been a law which authorises the direct killing of innocent persons after birth.

The lethal drugs most likely to be preferred by physicians are secobarbital and pentobarbital. These are the drugs prescribed in 99% of cases under Oregon's *Death With Dignity Act*.

Official reports give a complication rate of 4.9% for regurgitation.

The interval from ingestion of lethal drugs to unconsciousness has been as much as 38 minutes.

The interval from ingestion to death has been as long as 48 hours.

In 2005, one patient regained consciousness 65 hours after ingesting the medications, subsequently dying from their illness 14 days after awakening.³

Technical problems, complications and problems with completion in the administration of lethal drugs for euthanasia have also been reported from the Netherlands.

Technical problems occurred in 5% of cases. The most common technical problems were difficulty finding a vein in which to inject the drug and difficulty administering an oral medication.

Complications occurred in 3% of cases of euthanasia, including spasm or myoclonus (muscular twitching), cyanosis (blue colouring of the skin), nausea or vomiting, tachycardia (rapid heart beat), excessive production of mucus, hiccups, perspiration, and extreme gasping. In one case the patient's eyes remained open, and in another case, the patient sat up.

In 10% of cases the person took longer than expected to die (median 3 hours) with one person taking up to 7 days.⁴

In the light of this evidence it is doubtful as to whether all attempted acts of euthanasia would meet the Bill's definition of euthanasia as "*a gentle and peaceful death*".

5. Laws permitting euthanasia or physician assisted suicide in other jurisdictions

Despite a decades-old movement for legalised euthanasia in many countries in the developed world, only a handful of jurisdictions have legalised euthanasia. These are the Netherlands, Belgium and

Albania. The US States of Oregon and Washington have legalised physician assisted suicide. The Montana Supreme Court has found a loophole in that state's laws which permits physician assisted suicide. In Switzerland assisting suicide, other than for selfish motives, is not a crime.

Several high level inquiries into euthanasia have concluded that laws permitting euthanasia cannot be safely enacted.

5.1 United Kingdom

On 12 May 2006 the House of Lords voted 148-100 against the Assisted Dying for the Terminally Ill Bill. On 7 July 2009 the House of Lords voted 194-141 against a proposed amendment to the Coroners and Justice Bill, which would have protected from prosecution those who help a person to seek assisted suicide abroad.

These votes indicate that the House of Lords still considers as valid the conclusions of the House of Lords Select Committee of Medical Ethics 1994 report that society's prohibition of intentional killing should not be weakened.⁵ The select committee stated: "That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia."⁶

The House of Lords select committee also concluded that it is not possible to set secure limits on voluntary euthanasia and that, if a law permitting euthanasia were passed, then vulnerable people – the elderly, lonely, sick or distressed – would feel pressure, whether real or imagined, to request early death.⁷

5.2 Canada

In 1995 a Special Senate Committee on Euthanasia and Assisted Suicide reported, with a majority recommending that assisted suicide and voluntary euthanasia remain criminal offences.

In their view, legalization could result in abuses, especially with respect to the most vulnerable members of society. The ill and the frail are particularly dependent on those around them and on the health care system. Inevitably, and often without realizing it, these individuals cede control over their lives to the system and to those on whom they are dependent. For this reason, it would be difficult for others to assess whether an informed choice was made without coercion. If assisted suicide were legalized and accepted by the community, how could the expectations of the people surrounding the patient not influence his or her decision, particularly if the patient feels she or he is a burden on the family.

They think that some would feel pressured to resort to assisted suicide where financial and institutional resources are scarce. Financial restraints that affect the health care infrastructure could also result in attempts, perhaps unconsciously, to influence patients to die more quickly and conveniently. All of the above factors could make it difficult to establish whether a request for assisted suicide is voluntary.⁸

5.3 United States

5.3.1 New York Task Force on Life and the Law

The New York Task Force on Life and the Law in a 1997 supplement⁹ to its 1994 report, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*,¹⁰ affirmed and helpfully

summarised its views on the primary risks associated with the legalisation of assisted suicide or euthanasia as follows:

- *Undiagnosed or untreated mental illness.*

Many individuals who contemplate suicide – including those who are terminally ill – suffer from treatable mental disorders, most commonly clinical depression. Yet, physicians routinely fail to diagnose and treat these disorders, particularly among patients at the end of life. As such, if assisted suicide is legalised, many requests based on mental illness are likely to be granted, even though they do not reflect a competent, settled decision to die.

- *Improperly managed physical symptoms.*

Requests for assisted suicide are also highly correlated with unrelieved pain and other discomfort associated with physical illness. Despite significant advances in palliative care, the pain and discomfort that accompanies many physical illnesses are often grossly under-treated in current clinical practice. If assisted suicide is legalised, physicians are likely to grant requests for assisted suicide from patients in pain before all available options to relieve the patient's pain have been thoroughly explored.

- *Insufficient attention to the suffering and fears of dying patients.*

For some individuals with terminal or incurable diseases, suicide may appear to be the only solution to profound existential suffering, feelings of abandonment, or fears about the process of dying. While the provision of psychological, spiritual, and social supports – particularly, comprehensive hospice services – can often address these concerns, many individuals do not receive these interventions. If physician-assisted suicide is legalised, many individuals are likely to seek the option because their suffering and fears have not adequately been addressed.

- *Vulnerability of socially marginalized groups.*

No matter how carefully any guidelines for physician-assisted suicide are framed, the practice will be implemented through the prism of social inequality and bias that characterises the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, isolated, members of a minority group, or who lack access to good medical care.

- *Devaluation of the lives of the disabled.*

A physician's reaction to a patient's request for suicide assistance is likely to depend heavily on the physician's perception of the patient's quality of life. Physicians, like the rest of society, may often devalue the quality of life of individuals with disabilities, and may therefore be particularly inclined to grant requests for suicide assistance from disabled patients.

- *Sense of obligation.*

The legalisation of assisted suicide would itself send a message that suicide is a socially acceptable response to terminal or incurable disease. Some patients are likely to feel pressured to take this option, particularly those who feel obligated to relieve their loved ones of the burden of care. Those patients who do not want to commit suicide may feel obligated to justify their decision to continue living.

- *Patient deference to physician recommendations.*

Physicians typically make recommendations about treatment options, and patients generally do what physicians recommend. Once a physician states or implies that assisted suicide would be “medically appropriate,” some patients will feel that they have few, if any, alternatives but to accept the recommendation.

- *Increasing financial incentives to limit care.*

Physician-assisted suicide is far less expensive than palliative and supportive care at the end of life. As medical care shifts to a system of capitation, financial incentives to limit treatment may influence the way that the option of physician-assisted suicide is presented to patients, as well as the range of alternatives patients are able to obtain.

- *Arbitrariness of proposed limits.*

Once society authorises physician-assisted suicide for competent, terminally ill patients experiencing unrelievable suffering, it will be difficult, if not impossible, to contain the option to such a limited group. Individuals who are not competent, who are not terminally ill, or who cannot self-administer lethal drugs will also seek the option of physician-assisted death, and no principled basis will exist to deny them this right.

- *Impossibility of developing effective regulation.*

The clinical safeguards that have been proposed to prevent abuse and errors are unlikely to be realised in everyday medical practice. Moreover, the private nature of these decisions would undermine efforts to monitor physicians’ behaviour to prevent mistake and abuse. We continue to believe that these profound dangers associated with legalising physician-assisted suicide outweigh any benefits which such a change in law might achieve in isolated cases.

5.3.2 Oregon

From 1994 through 2007, no fewer than 89 legislative proposals in 22 states of the United States that would have legalised assisted suicide have failed.¹¹

The only proposals to succeed to date have been in Oregon where the *Death With Dignity Act* has been in operation since 1997 and in Washington where a physician assisted suicide initiative passed in November 2008.

An analysis of the ten years operation of Oregon’s *Death With Dignity Act* has been carried out by the International Task Force on Euthanasia and Assisted Suicide¹².

Issues identified in this analysis include:

- Complications arising from self-administration of medication, including vomiting, and one case of a person being unconscious for 65 hours and then waking up.
- Possible coercion or undue influence by a family member on a woman with dementia to request physician assisted suicide.
- Patients with a history of depression being prescribed lethal drugs without a psychiatric referral, which is optional under Oregon’s law.
- Oregon’s Medicaid program funds an ever decreasing list of medical treatments while assisted suicide remains Medicaid funded.

- Although Oregon's law limits physicians to prescribing lethal drugs to those whose life expectancy is six months or less, official reports indicate that several of those who have taken lethal drugs prescribed under the law have done so more than six months after the drugs were prescribed.
- Although Oregon's law requires at least 15 days between a patient's first request for a lethal prescription and the supply of the prescription, official reports indicate that this condition is often breached.

Patients have taken up to 83 hours to die after ingesting the prescribed lethal drugs.¹³

5.4 The Netherlands

Since legalised euthanasia was introduced in the Netherlands, initially by court decision (1973) and subsequently by statute (2002), there is no doubt that there has been a rapid expansion of the categories of people considered eligible for physician administered death.

Children aged 16 and over can request euthanasia without parental agreement.

Children aged 12 to 16 can be killed by euthanasia if they request it and a parent agrees.

Children up to the age of 12, including newborns, may be killed by lethal injection with parental consent.

Psychiatric conditions such as depression or anorexia have been accepted as sufficient justification for requesting euthanasia.

Despite the official requirement for consent, *involuntary* euthanasia occurred in between 500 and 1000 cases each year from 1995 through 2005.¹⁴

The architect of the euthanasia laws in the Netherlands seems to be having second thoughts.

*Dr Els Borst, the former Health Minister and Deputy Prime Minister who guided the law through the Dutch parliament, now says it was brought in 'far too early' ... she admitted that medical care for the terminally-ill had declined since the law came into effect. She said more should have been done legally to protect people who wanted to die natural deaths. 'In the Netherlands, we first listened to the political and societal demand in favour of euthanasia,' said Dr Borst. 'Obviously, this was not in the proper order.'*¹⁵

And palliative care in the Netherlands is below standard.

*Dr The, who has studied euthanasia for 15 years, said that palliative care was so inadequate in Holland that patients 'often ask for euthanasia out of fear' of dying in agony because care and pain relief is so poor.*¹⁶

6. Australia

6.1 Northern Territory

The *Rights of the Terminally Ill Act 1995* (ROTI) was in operation in the Northern Territory from 1 July 1996 until the practice of euthanasia became unlawful again, with the commencement of the Euthanasia Laws Act 1997 on 27 March 1997.

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 that “(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))

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. No other medical practitioner made use of the provisions of the ROTI Act to assist any other person to terminate his life.

Case studies on the four deaths under the ROTI Act, along with three other case studies of persons who sought to make use of the provisions of the ROTI Act before or after it was in operation, have been published.¹⁷ The principal author of this paper is Professor David Kissane, who is a consultant psychiatrist and professor of palliative medicine. Dr 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 Nitschke.

6.1.1 Terminal illness and further treatment options

In one of the four cases, 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.”¹⁸

In case 3 the patient may have benefited from radiotherapy or strontium but neither of these was available in the Northern Territory.¹⁹

In case 5, the patient had an obstruction and was clinically jaundiced.²⁰ 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.”²¹ 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.”²²

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.²³

6.1.2 “Severe Pain or Suffering”

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 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.”

6.1.3 No clinical depression

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

In case 3, the patient had had “counselling and anti-depressant medication for several years”.³² 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 at home 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.”³³

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.”³⁴ While Dr Nitschke “judged this patient as unlikely to respond to further treatment” his co-author Professor David 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.”

A 1996 survey of Oregon psychiatrists³⁵ found that “two-thirds of Oregon psychiatrists believe that physician-assisted suicide for competent terminally-ill persons should, under certain circumstances, be permitted. A slim majority favored implementation of Oregon’s *Death With Dignity Act*, which would legalise physician-assisted suicide.” However, the survey also found that “Ninety-four percent were not very confident, however, that within the context of a single evaluation they could determine whether or not a psychiatric disorder was impairing the judgment of a patient who was requesting assisted suicide.”

This raises serious doubts about the adequacy of the provision in the *Rights of the Terminally Ill Act 1995* for confirming the absence of a treatable clinical depression.

These doubts are strengthened by the report on case 5.³⁶ 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 as was permitted under the ROTI Act. 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.³⁷

6.1.4 Senate Committee

An examination of the Northern Territory’s experience with legalised euthanasia was undertaken by the Senate Legal and Constitutional Affairs Committee in 2008. A majority (5-3) of the Committee recommended against the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008*, which sought to restore legalised euthanasia in the Northern Territory.

6.2 Other Australian states

The *Medical Treatment (Physician Assisted Dying) Bill 2008* was defeated in Victoria’s Legislative Council in September 2008 by 25-1.

The *Dying with Dignity Bill 2009* was defeated in Tasmania’s House of Assembly by 15-7 after an inquiry into the Bill by the Joint Standing Committee on Community Development found that the Bill

did not “*provide an adequate or concise legislative framework to permit voluntary euthanasia/physician assisted suicide.*”

The *Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008* was defeated in South Australia’s Legislative Council in December 2009 by 11-9.

7. Dr Phillip Nitschke

Any jurisdiction in Australia considering legalising euthanasia must anticipate that if euthanasia were to be legalised it is highly likely that Dr Phillip Nitschke would be among the first to take advantage of the new law to administer euthanasia.

He has been registered as a medical practitioner in Western Australia since 1999.

As demonstrated by the analysis of the deaths he was responsible for in the Northern Territory when euthanasia was briefly legal there, the prospect of Dr Nitschke establishing a legal euthanasia practice in Western Australia should be cause for concern.

After the conviction of two women for the manslaughter of Alzheimer’s sufferer Graham Wylie, Dr Nitschke is reported to have said that he “*will urge Alzheimer's patients who contact his organisation, Exit International, not to go to a doctor, to avoid legal complications around their premature death.*”

In contrast to expert evidence given in court Dr Nitschke asserted that: “*Many people said this person [Graham Wylie] knew what he was doing. I thought he knew what he was doing. Yet they [those giving expert evidence] base it on the medical evidence that he had lost his ability to make a decision, that he had lost his ability to say whether he could die or not. We'll be advising people not to [declare they have Alzheimer's]. Don't go to your doctor. Don't have the tests done. And if you do have the tests done that show that you're starting to lose mental capacity, make sure it is not recorded.*”³⁸

There is clearly no reason to trust Dr Nitschke’s judgement as to whether a patient making a request for euthanasia should be referred to a psychiatrist or not. However, the Bill has no provision for dealing with this situation. It leaves the decision entirely in the hands of any medical practitioner, including those with a history of poor judgment on such matters, like Dr Nitschke.

8. Conclusion and recommendation

A law permitting euthanasia would undermine society’s prohibition of intentional killing of innocent people, which is an indispensable foundation of the rule of law.

In the light of international and Australian (Northern Territory) experience with laws permitting euthanasia or physician assisted suicide, it can be concluded that it is not possible to enact a law permitting euthanasia that has adequate safeguards to prevent its abuse.

This conclusion would be sufficient reason to oppose this Bill.

However, this Bill has additional serious flaws. It doesn’t even attempt to provide the safeguards attempted in the Northern Territory’s Rights of the Terminally Ill Act 1995. It has no requirement for any specialist expertise in diagnosing the condition and the prognosis. Nor does require assessment by a psychiatrist.

It permits a medical practitioner to give a lethal substance to a person who may:

- have years to live (if not properly diagnosed);

- be suffering from depression, suicidal ideation or demoralisation, but is never referred to a psychiatrist for assessment let alone treatment;
- be suffering no physical pain at all, but who states he or she is suffering (which may be psychological or emotional) or debilitated (weak or lacking energy).

Recommendation:

Since the Bill would undermine the protection given to all Western Australians by the law against homicide, and it would place vulnerable people at risk of medicalised homicide, it should not be supported.

9. Endnotes

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