Submission

to the

Voluntary assisted dying review

by the

Queensland Law Reform Commission

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Table of Contents

1. Introduction 1

2. Euthanasia and assisted suicide 2

2.1. Definitions 2

2.2. Issues 2

3. Conclusion 5

4. Endnotes 6

1. Introduction

FamilyVoice Australia is a national Christian advocacy group – promoting family values for the benefit of all Australians. Our vision is to see strong families at the heart of a healthy society: where marriage is honoured, human life is respected, families flourish, Australia's Christian heritage is valued, and fundamental freedoms are enjoyed.

Terms of reference

On 21 May 2020, the Acting Attorney-General and Minister for Justice and Acting Leader of the House, gave the Commission terms of reference to develop 'an appropriate scheme for voluntary assisted dying and to prepare draft voluntary assisted dying legislation to give effect to its recommendations'. It further provides:

Scope

The provision of compassionate, high quality and accessible palliative care for persons at their end of life is a fundamental right for the Queensland community.

The Queensland Law Reform Commission is asked to make recommendations about an appropriate voluntary assisted dying scheme and to prepare draft voluntary assisted dying legislation to give effect to its recommendations, with particular regard to:

1. *the best legal framework for people who are suffering and dying to choose the manner and timing of their death in Queensland;*
2. *identifying who can access voluntary assisted dying;*
3. *the process for access to voluntary assisted dying to be initiated, granted or denied;*
4. *the legal and ethical obligations of treating health practitioners;*
5. *appropriate safeguards and protections, including for treating health practitioners;*
6. *ways in which compliance with the Act can be monitored;*
7. *timeframes for implementation of a scheme in Queensland, if progressed.*

In preparing draft legislation, the Commission is also to have regard to the following:

A. *The Parliamentary Committee's Report No 34, Voluntary assisted dying, including the draft legislation in Appendix A of the Report (VAD Report) and Information Paper No 5, Summary of the Findings and recommendations from Report No 34 on Voluntary assisted dying (Information Paper No 5);*
B. *The Parliamentary Committee's Report No 33, Aged care, end-of-life and palliative care (AEP Report);*
C. *Consultation with stakeholders and the community that occurred during the Parliamentary Committee's consideration of the matter;*
D. *Views of experienced health and legal practitioners;*
E. *Views of the Queensland public;*
F. Legislative and regulatory arrangements in other Australian and international jurisdictions.

The Commission is required to provide its final report for the review and draft legislation by 1 March 2021.

Submissions are due, **Friday 27 November 2020**.

2. Euthanasia and assisted suicide

The Commission has made clear that it is not interested in hearing about the risks associated with euthanasia and assisted suicide – that is to say, it does not want to hear about "if", but is only concerned with "how".[1] The Commission states that the scope of its "reference is limited to developing an appropriate legal framework for voluntary assisted dying."[2]

The reality is that there is no "appropriate legal framework" to kill people, or to assist them to kill themselves.

The legalisation of euthanasia and assisted suicide by its very nature places the lives of Queenslanders at risk, as detailed in this submission.

2.1. Definitions

Though not necessarily taken by contemporary medical professionals, the Hippocratic Oath has informed medical ethics since the fifth century BC. In its original form, the oath includes the declaration: "I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan".[3]

The role of doctors and medical professionals is to save lives – not end them. Consequently, euthanasia and assisted suicide should not be considered a component of medical treatment.

Some confusion surrounding end-of-life issues is caused by a misunderstanding of definitions. The Australian Medical Association (AMA) provides the following explanations of euthanasia and assisted suicide:

> *Euthanasia is the act of deliberately ending the life of a patient for the purpose of ending intolerable pain and/or suffering.*
>
> *Physician assisted suicide is where the assistance of the medical practitioner is intentionally directed at enabling an individual to end his or her own life.*[4]

Euthanasia and assisted suicide are, therefore, the intentional ending of a life and should not be confused with medical end-of-life considerations. The AMA provides some points of clarification:

> *the following forms of management at the end of life **do not** constitute euthanasia or physician assisted suicide:*
>
> - *not initiating life-prolonging measures;*
> - *not continuing life-prolonging measures;*
> - *the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.*[5]

If laws were changed to allow euthanasia or assisted suicide, medical training would need to include courses on how to kill patients. Doctors would then be equipped to treat or kill their patients. This would forever destroy the bond of trust between doctor and patient.

2.2. Issues

The following list is far from exhaustive, but provides some examples as to why euthanasia and assisted suicide should not be considered by policymakers.

Pressure on vulnerable people

The introduction of laws for euthanasia and assisted suicide risks the wellbeing of society's most vulnerable members. These include the sick, elderly or disabled, who may feel themselves to be a burden on their loved one.

Experience in Oregon (US), which has "physician-assisted dying", shows that physical suffering is not a major issue for those requesting physician assisted suicide – but fear of being a burden is.

Of the 673 people who had died under the provisions of the Act as of 14 January 2013, only 23.5% listed "inadequate pain control or concern about it" as a consideration.[6]

Earlier annual reports noted: "Patients discussing concern about inadequate pain control with their physicians were not necessarily experiencing pain."[7]

By contrast some 38.6% of those who died after taking prescribed lethal medication cited concerns about being a "burden on family, friends/caregivers" as a reason for the request.[8]

Euthanasia and assisted suicide seem to be more about relieving other people of a "burden" than relieving unbearable or unrelievable suffering.

Mixed messages on suicide

Euthanasia and assisted suicide laws jeopardise the health of those struggling with depression and mental illness.

Sending a mixed message on suicide undermines the excellent work of mental health groups, both government and NGO, and sends the wrong message in a country with one of the highest youth suicide rates in the world.

According to the most recent figures, Australian suicide rates have reached an equal 10-year high and remain the leading cause of death for Australians aged between 15 and 44:

> *In 2017, in Australia, 3,128 people died from intentional self-harm (X60-X84, Y87.0) rising 9.1% from 2,866 in 2016. The preliminary standardised death rate for 2017 was 12.6 deaths per 100,000 persons (see graph below) and was equal with 2015 as the highest recorded preliminary rate in the past 10 years. This compares with a final rate of 10.9 suicide deaths per 100,000 persons in 2008. Intentional self-harm was ranked the 13th leading cause of death in 2017, moving up from 15th position in 2016.*[9]

Not only does consideration of euthanasia and assisted suicide undermine efforts for better mental health, there have been suggestions the debate is directly linked to a higher instance of youth suicide.

A 2007 article casts light on this connection:

> *Young Australian men in their prime commit suicide at the rate of nearly 400 per year. In 1997, when the Federal Parliament held a conscience vote on the contentious issue of the Northern Territory's euthanasia legislation, suicide peaked among Australia's 20-24 male population, reaching 40 per 100,000, which is nearly twice the current rate*
>
> *As with copy-cat behaviour, merely drawing attention to the supposed right to take one's own life has only encouraged the practice.*[10]

Legalisation of euthanasia and assisted suicide creates a perception that some lives are worth more than others – and that there is a point at which life is no longer worth living. This message must be rejected.

Provision of palliative and psychiatric care

The practice of euthanasia has been found to have serious flaws in terms of patients seeking access to palliative care or psychiatric treatment.

The radical step of ending or taking a life would surely be considered only after all other avenues have been explored – yet the Belgian experience shows this is not the case. Disturbingly, a majority of euthanased patients were not previously visited by a palliative care team.

Barely a fraction of euthanased patients received a visit from a palliative care specialist or a psychiatric consultation, as a 2015 Belgian study documents:

> *When analysing the latest data provided by the Belgian Federal Euthanasia Commission (years 2012–2013), we see that only 40 percent (1,283 out of 3,239) of the euthanized patients had a visit by a palliative care team, barely 12 percent (396 out of 3,239) had a visit by a palliative care specialist, and just 9 percent (307 out of 3,239) were consulted by a psychiatrist (Commission Fédérale de Contrôle et d'Évaluation de l'Euthanasie 2014). Thus almost 40 percent of the patients who received euthanasia did not see a palliative care specialist nor interacted with a palliative care team.*[11]

Given that pain and suffering are frequently-cited arguments in favour of euthanasia, it is concerning that experience shows euthanasia to be a first resort, rather than professional pain management. Likewise, considering the likelihood of depression and other mental health issues in such cases, it is alarming that appropriate care has been supplanted under a euthanasia regime.

It is entirely foreseeable that a similar situation could develop were euthanasia or assisted suicide to be countenanced in Queensland. This is especially the case with an ageing population creating greater demand for palliative care and other health services.

Effect on family and friends

There is also a question of the mental wellbeing of others involved in euthanasia and assisted suicide cases.

In Switzerland, a study found that about 20 per cent of family members or friends who witnessed an assisted suicide subsequently suffered from full (13 per cent) post-traumatic stress disorder or sub-threshold (6.5 per cent) post-traumatic stress disorder.[12]

In short, a significant number of a patient's family and friends are likely to suffer severe stress following the patient's premature death.

Child euthanasia

Warnings of euthanasia being a "slippery slope" have been validated by, among other consequences, the introduction of child euthanasia.

This abhorrent practice now occurs in several countries, either by de facto acceptance or with complete legality. Two examples are the Netherlands and Belgium.

Euthanasia is permitted in the Netherlands for patients aged 12 and over. Despite the supposed illegality of euthanasing children below that age, practice has long been different.

The Groningen Protocol, drafted in 2004 after extensive consultation between doctors, lawyers, parents and public prosecutors, provides criteria under which a child under aged 12 can be euthanased. While it does not provide a complete legal protection for doctors, it has resulted practically in a functioning regime for child euthanasia.

The Royal Dutch Medical Association has estimated that of newborn babies alone, some 650 are killed every year.[13]

Belgium, meanwhile, became the first country to officially legalise child euthanasia in 2014 – with no age limit. Trends indicate that Belgian child euthanasia numbers will likely increase.

Belgium introduced euthanasia laws in 2002. In 2012, there were 1432 recorded cases of euthanasia – an increase of 25 per cent from the previous year. From these figures, it is reasonable to envisage the Dutch child euthanasia numbers being replicated – or even exceeded – in Belgium.

Aside from questions of a child's capacity to make such a decision (namely, to end their own life), the Dutch and Belgian experience again demonstrates that acceptance of euthanasia or assisted suicide invariably affects the most vulnerable members of society.

Recommendation

The Queensland Law Reform Commission should recognise the reality that there is no "appropriate legal framework" to kill people, or to assist them to kill themselves.

3. Conclusion

The legalisation of euthanasia and assisted suicide by its very nature places the lives of Queenslanders at risk.

The Queensland Law Reform Commission should recognise the reality that there is no "appropriate legal framework" to kill people, or to assist them to kill themselves.

Concerns raised here regarding euthanasia and assisted suicide are far from exhaustive. Those particular issues have been raised to give an idea of the deleterious effects caused by such laws.

Whenever lives are deliberately cut short, regardless of the legal framework, there are severe ramifications – not only for patients concerned, but also for family and friends, other vulnerable people, medical professionals, and whole societies.

4. Endnotes

[1] Queensland Law Reform Commission, "A legal framework for voluntary assisted dying" consultation paper, October 2020, paras 1.7 – 1.9, https://www.qlrc.qld.gov.au/__data/assets/pdf_file/0003/658506/qlrc-wp-79-2020.pdf

[2] Queensland Law Reform Commission, "A legal framework for voluntary assisted dying" consultation paper, October 2020, para 1.9, https://www.qlrc.qld.gov.au/__data/assets/pdf_file/0003/658506/qlrc-wp-79-2020.pdf

[3] *Greek Medicine – The Hippocratic Oath*, National Institutes of Health, https://www.nlm.nih.gov/hmd/greek/greek_oath.html

[4] Australian Medical Association, *Position Statement on the Role of the Medical Practitioner in End of Life Care 2007 (amended 2014)*, https://ama.com.au/sites/default/files/documents/ps_on_the_role_of_the_medical_practitioner_in_end_of_life_care_2007_amended_2014_0.pdf

[5] Australian Medical Association, *Position Statement on the Role of the Medical Practitioner in End of Life Care 2007 (amended 2014)*.

[6] Oregon Health Authority, Oregon's *Death With Dignity Act -2012 Table 1, Characteristics and end-of-life care of 673 DWDA patients who died after ingesting a lethal dose of medication as of January 14, 2013, by year, Oregon, 1998-2012*, p 4.

[7] Oregon Health Authority, *Sixth Annual report on Oregon's Death With Dignity Act,* 2004, p 24.

[8] Oregon Health Authority, Oregon's *Death With Dignity Act -2012 Table 1, Characteristics and end-of-life care of 673 DWDA patients who died after ingesting a lethal dose of medication as of January 14, 2013, by year, Oregon, 1998-2012*, p 4.

[9] "3303.0 - Causes of Death, Australia, 2017", ABS Statistics, https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3

[10] John Morrissey, "Male suicide rise linked to euthanasia debate", *News Weekly*, March 3, 2007, http://newsweekly.com.au/article.php?id=3058

[11] Tom Mortier, René Leiva, Raphael Cohen-Almagor & Willem Lemmens, *Between Palliative Care and Euthanasia*, Journal of Bioethical Inquiry, 22 April 2015.

[12] B. Wagner et al., "Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide", *European Psychiatry*, 2012, 27: 5422-26.

[13] Sue Reid, "The country where death is now just a lifestyle choice", *Daily Mail*, 2 January 2015, http://www.dailymail.co.uk/news/article-2893778/As-debate-assisted-suicide-dispatch-Holland-thousands-choose-die-year.html