JOINT SELECT COMMITTEE ON END OF LIFE CHOICES

INQUIRY INTO THE NEED FOR LAWS IN WESTERN AUSTRALIA TO ALLOW CITIZENS TO MAKE INFORMED DECISIONS REGARDING THEIR OWN END OF LIFE CHOICES

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
TUESDAY, 1 MAY 2018

SESSION EIGHT

Members

Ms A. Sanderson, MLA (Chair)
Hon Colin Holt, MLC (Deputy Chair)
Hon Robin Chapple, MLC
Hon Nick Goiran, MLC
Mr J.E. McGrath, MLA
Mr S.A. Millman, MLA
Hon Dr Sally Talbot, MLC
Mr R.R. Whitby, MLA

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Hearing commenced at 3.16 pm

Professor MARGARET ANNE SOMERVILLE
Professor of Bioethics, University of Notre Dame Australia, Sydney, examined:

The CHAIR: Thanks very much for joining us, professor. On behalf of the committee, I would like to thank you for agreeing to appear today to provide evidence in relation to the end-of-life choices inquiry. My name is Amber-Jade Sanderson. I am the Chair of the joint select inquiry. We have Mr Simon Millman; Hon Dr Sally Talbot; Mr John McGrath; next to me will be Dr Jeannine Purdy, our principal research officer; Hon Colin Holt; Hon Nick Goiran; Mr Reece Whitby and Hon Robin Chapple.

The committee has agreed to invite you to appear today because when Reverend Margaret Court of Victory Life Centre gave evidence in March, she indicated that she had relied extensively on your academic work and recommended that we hear directly from you. You have agreed to provide evidence to the committee, and this evidence is protected by parliamentary privilege in Western Australia and protected by uniform defamation laws in Australia against actions of defamation. Please note that these protections do not apply to anything that you might say outside of today's proceedings. It is important you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. I advise that the proceedings of this hearing will be broadcast live within Parliament House and via the internet, and the audiovisual recording will be available on the committee's website following the hearing. Would you please introduce yourself for the record?

Prof. SOMERVILLE: Yes. My name is Margaret Anne Ganley Somerville. I am an Australian, and also a Canadian. My current position is Professor of Bioethics at the University of Notre Dame Australia Medical School in Sydney. I am also emeritus Samuel Gale Professor of Law, emeritus professor in the faculty of medicine, and emeritus founding director of the centre for medicine, ethics and law at McGill University in Montreal, where I worked for just over 40 years.

The CHAIR: Thank you. Do you have any questions about your attendance today?

Prof. SOMERVILLE: No, not really.

The CHAIR: Did you want to make an opening statement for the committee?

Prof. SOMERVILLE: Yes, certainly. That is what you would like, is it?

The CHAIR: Yes please.

Prof. SOMERVILLE: Thank you for having invited me, I really appreciate it. This is a topic that I have been involved with for about 35 years and I have written extensively on it. I thought that you would probably have heard most of the arguments both for and against, so I thought that I would just flag the ones that I think are important.

First of all, the definition of "physician-assisted suicide" and "euthanasia" are very important and there is a great deal of confusion about it, not only in the general public, but also, somewhat surprisingly, even in the healthcare professions, including medicine. It is not withholding treatment or provision of fully adequate pain management. What it is, is acting with the intention to end the life of the patient and using the means to do that or otherwise giving them advice—my cat has just walked up onto the table! Obviously, he can see I am occupied!

The CHAIR: He is very welcome to join us!

Prof. SOMERVILLE: If it is physician-assisted suicide, it is giving somebody the means to take their own life and the person giving those means has the intention that they would use those means to do so.

Secondly, euthanasia is not a step on the continuum of good end-of-life care as pro-euthanasia advocates claim. It is a seismic shift in two things—medicine's ethos and society's foundational values.

Third, the case for euthanasia and physician-assisted suicide, and I will now just use the word "euthanasia" to include both, focuses on an individual person who wants euthanasia and it looks only at the present. In other words, it is a radical individualism and what I call "presentism". I suggest that we have got to look further than that and we have got to look at the consequences—the individual is important, but it is not sufficient—and we have got to look not only in the present, but lessons from the past around human memory and we have got to use our vivid imaginations to see what this might mean for the future. I believe that if you as legislators and all of us as citizens of Australia did that, we would decide that legalising euthanasia is a bad idea, as, indeed, several other countries have decided. It is very interesting in the media that you usually only get reports that euthanasia is approved. For example, in the United States, seven states have approved physician-assisted suicide, but, indeed, not euthanasia, which is interesting, but 17 states have expressly rejected it and you do not usually hear that. Euthanasia is not medical treatment. It has not been recognised as such for at least 2 500 years, since the Hippocratic oath. If you are at all interested in looking in depth at that, a colleague of mine at McGill, Dr Donald Boudreau, and I wrote a paper, which is available. It is called "Euthanasia is not medical treatment", and it is online. I propose we have to take the "white coat" off euthanasia because it confuses people as to what it is and its ethical acceptability. Euthanasia violates the fundamental bond of trust between doctor and patient. There is an interesting new article out by a group of American medical students and this is what they say: "Doctor–patient trust is founded upon the notion that doctors will commit to doing their best to heal and care for patients and not intentionally kill those trusted to their care." They say that that they do not approve of bringing that into the profession that they are joining.

Euthanasia seriously harms the value of respect for life, which has to be upheld at two levels, which is sometimes forgotten: respect for every individual human life and respect for human life in the society in general. Respect for life is not just a religious value as pro-euthanasia advocates argue; it is a fundamental value in every civilised society and I propose to you that we cannot afford to damage that value. Whatever reason you are using euthanasia for, it does damage that value.

Current evidence shows that claims that euthanasia will not open up a "logical" or "practical" slippery slope are simply not true. The logical slippery slope is the extension of people's access in which they can obtain euthanasia. The practical slippery slope recognises that, once euthanasia is legal, cases can be taken out and are undertaken not in compliance with the law. There are some very startling examples demonstrating these slopes in which formerly strong advocates of legalising euthanasia, indeed people who undertook to get it legalised, have declared themselves shocked in how it is being used, well beyond the people and circumstances they initially anticipated. In another context, Dame Mary Warnock said, "You cannot successfully block a slippery slope except by a fixed and invariable obstacle", and that obstacle in the euthanasia debate is the absolute rule that we must not intentionally kill another human being, and in particular doctors must not kill their patients.

It is argued that there could be adequate safeguard rules and regulations, and again that is simply not true. The safeguards are not complied with. For example, last week there was a report from Belgium. In the Flanders region of Belgium a study showed that only 15 per cent of euthanasia cases

were being reported as is required by the law; that is, there was an underreporting of 550 per cent. If you need a reference for that, I can provide it for you. Something that is not recorded is that the cost of safeguarding euthanasia would be extremely high. There is an organisation in Canada called the Vulnerable Persons Standard and they are working out what would be needed to try to make it safe and it requires extensive monitoring and reporting, and at present that is not being done in jurisdictions that have legalised euthanasia. In fact, there is concern being expressed both in the Netherlands and Belgium that the reporting and monitoring is totally inadequate. Vulnerable people, especially fragile elderly people and those with disabilities, are placed at high risk, and even if they were not, euthanasia devalues them and their lives. It sends a message that they have got lives not worth living, and if you listen to them, they will tell you that. We are also aware that the Australian Law Reform Commission has reported that there is serious concern about elder abuse, and they looked at "early inheritance syndrome", where people get a power of attorney and use a person's financial assets. If you combine that with "early death syndrome", which is what euthanasia enables, you have got a lethal cocktail I would suggest to you.

There are claims that euthanasia would be rarely used and only as a last resort. That has not proven true. Euthanasia is very quickly normalised. It is estimated that by 2025, 20 per cent of deaths in Belgium will be from euthanasia. I recently received a letter—it is a public letter, not written to me personally—from Dr Yves Robert, who was one of the main people advocating for legalising euthanasia in Canada. He is the registrar of the college of physicians and surgeons of Quebec, and I debated him quite often. He is a very nice man and they were polite debates. He advocated euthanasia and I argued against. Anyway, he has just put out this letter. It is in French and it is called "Death on demand", and he has expressed himself totally shocked at what has happened in Quebec in the two years since euthanasia was legalised. There are now claims in Quebec, and they think that there may be court case, for death on demand. What is being argued is that it is discrimination to require certain conditions to be fulfilled to have a doctor have to approve euthanasia, because it is a matter of individual autonomy to have the right to simply have death if that is what they want. The same claim is being made in the Netherlands and has been implemented in what is called an end-of-life choices clinic, which is providing euthanasia for people who cannot get permission from other doctors and who do not have physical illness, but have mental illness.

[3.30 pm]

Dr Chabot, who was the person who put himself on the line—he is a psychiatrist in the Netherlands—to get euthanasia legalised in that country. He has gone on record just about six weeks ago saying he never anticipated this would happen, and he totally opposes it. So I think we are fortunate that we have got those early warnings.

In short, euthanasia is harmful to patients, patients' families, healthcare professionals—especially doctors—to society, and to society's most important values. We have also got research that shows that the Dutch medical association is worried about this; the doctors who do euthanasia are suffering post-traumatic stress disorder; and about 20 per cent of family members that are present at euthanasia have some sort of collateral mental damage themselves. I think, again, those are things that we must take into account. I would urge you to reject physician-assisted euthanasia. But if society wants it and you pass legislation to allow it, please, please keep it out of medicine, for many, many reasons. What we would suggest, if that is the case—I do not promote this, but I think it is something that needs to be considered—would be that a separate group of people, a profession, would be trained to do this, but outside of medicine for a whole lot of reasons.

Finally, euthanasia is not necessary in any but the rarest of cases if we have good palliative care to which people can have access. Unfortunately, that is not the case for a lot of people in our country.

I know it is not the case in Canada, and since I have been back I have heard that it is also not the case in Australia. My brother died here in 2010. I can remember being frantic—I am somebody who has quite a lot of pull in relation to healthcare professionals—and I could not get the care I needed for my brother in terms of pain management. I suggested this elsewhere, and it ended up as a headline on the front page of a Canadian paper, that any healthcare professional who leaves a person in serious pain should be charged with a criminal offence. They put a headline on the front page of the *Ottawa Citizen* that said, "Ethicist recommends jailing doctors". Of course, you can imagine what that did. It caused a huge fuss. Anyway, that is what I would like to put before you.

The CHAIR: Thank you very much, Professor Somerville. I appreciate that. We do have access to quite a bit of that material through the submission put in by Victory Life Church and Reverend Margaret Court. I have a couple of questions about some of the evidence you just gave. You cited that in Belgium, 50 per cent of euthanasia is not being reported. We heard that in evidence yesterday as well. I am just interested to know, if it is not being reported, how is that data being captured?

Prof. SOMERVILLE: I have not actually got the reference here but I looked at the study today. I would have to find the reference for you and send it. It was a study carried out by surveying doctors in the Flanders region of Belgium and asking had they done euthanasia and had they reported it[1]. The result of this survey study was that of the total number of cases of euthanasia reported in the survey, only 15 per cent had been reported to the authorities as required by the legislation. But we know the same thing happens in the Netherlands. When the Netherlands euthanasia was approved, originally it had a very high rate of non-reporting. The other issue about reporting is that it is very hard to follow the death records and know if euthanasia was involved, because quite a few jurisdictions, including Quebec, actually, require that you put down a disease from which the person was suffering and you do not put down that they died by euthanasia. Of course, the lawyers have talked about that. That is actually a crime of false reporting of a vital statistic that is required by law.

Hon ROBIN CHAPPLE: I am paraphrasing what you said, doctor, and thank you for attending. You talked about that if legislation was to be brought in, it should not involve doctors and should be about another agency or another organisation. There is obviously an efficacy issue around this. Can you provide guidance or interpretation of what you see that organisation looking like?

Prof. SOMERVILLE: In the paper that my colleague Dr Boudreau and I wrote, which I mentioned, we have explored that a little bit. I want to make it very clear, I am not recommending this. I do not think that we should be legalising one human being to intentionally kill another human being, particularly not when they are vulnerable and ill, one would assume. What we suggested in that paper, we looked for a precedent where law had authorised the killing of a person. Of course the easiest precedent to look at is capital punishment, which I also do not approve of. But we went back and we looked at the hangman's bible from the turn of the nineteenth to the twentieth century in England, because that was a group of hangmen who were specially trained. They had to pass an exam that they would be an efficient hangman. We looked at that and considered how would you adapt that if you were thinking of a separate group of people? One of the suggestions that has been in the literature—this is not my original suggestion—is that we want a group of people who are trained to clearly understand the law and apply it strictly. Then you ask, "Who are those people?", and it is lawyers. That is who those people are. I was speaking here in Australia several years ago and I said that we cannot have doctors killing people. A friend of mine who is also palliative physician and one of the rare ones who approves of euthanasia, Dr Roger Hunt, jumped up in the audience

[1] Clarification: They were not asked for this information. Rather the reports of carrying out euthanasia were compared with the government statistics on its reporting.

and said, "Margo, would you stop using that word 'killing'? It is not killing". I said, "What is it?", and he said, "It's VAE." I asked him what that stood for and he said voluntary assisted euthanasia.

I went on in the speech and I made the suggestion that if we do it, let us keep it out of medicine, and who should it be, and I said lawyers. Roger rose to his feet and yelled out across the audience and said, "Margo, are you crazy? You would have lawyers killing people?" So when it was lawyers, it was seen as what it was; when it was doctors, it was not. That is because people find it very hard to believe that a doctor would do anything that was not ethical and entirely within their own, and just their own, best interests. We know that from what is called the "therapeutic misconception syndrome" in research—medical research. Even when you give a full explanation that this research will be of no benefit to you, when you go back and interview those people who were in the research study, they say things such as, "I really think this has helped me", and you have already told them that it is not going to do that. So people trust doctors, and that trust is enormously important. You have to have trust in the medical institution, and that is also involved here.

Mr R.R. WHITBY: Professor, with your proposed organisation, would it not simply be easier to allow the many doctors who have told us and spoken out elsewhere who support voluntary assisted dying to be those who would be involved?

Prof. SOMERVILLE: What I am arguing is that it must be kept out of medicine, because once you get it in medicine, I think we will have a breach of the ethos of medicine. The informing and guiding principle of medicine for two and a half thousand years, at least, is "care always, cure where possible, never kill", never act with intention to destroy life, and this contradicts that. I think the other question you have to ask is: why now are we thinking that this is a good idea when we have rejected it for thousands of years in our kind of society? I would suggest to you that there is a huge coincidence of factors that are causing this. I think when you look at those, there is very good reason to be concerned. I have got no doubt that the pro-euthanasia people are well meaning, they feel compassion, and they want to relieve suffering and pain; and so do I. But I think we have to kill the pain and suffering, not the person with the pain and suffering, for a whole lot of reasons that go beyond that individual person.

[3.40 pm]

Mr R.R. WHITBY: And yet we have evidence daily that on some occasions in palliative care—it varies between two to five to 30 per cent of occasions—that suffering cannot be addressed adequately.

Prof. SOMERVILLE: That is not what the palliative care people say. I mean, if you use palliative sedation, you can adequately address that suffering. Sometimes it is difficult, but not very often. I am not a palliative care specialist, but I work with them in this area and I am told that that is simply not correct.

Mr R.R. WHITBY I just wanted to make the point that we have heard evidence from palliative care doctors who have maintained that it is not always possible. I think you mentioned earlier that assisted dying would be a very rare event. I agree with you; I think it would be a very rare event. But you also mentioned that 20 per cent of deaths in Belgium could be attributable to euthanasia. How do you account for that disparity between suggesting that it would be a rare event and that in Belgium at least the numbers suggest it would not be?

Prof. SOMERVILLE: Can I just reply to the rare event? Mr Andrew Denton, he and I were on a panel with the AMA in Victoria a few months ago, and he said it will be a rare event. But he also says that it will be about the same rate as in the Netherlands and Belgium. The current rate of euthanasia in those countries is around four per cent of all deaths. If you apply that to the Australian death statistics, which I did, that would be about 6 000 cases a year in Australia, which is certainly not a

rare event. I have forgotten what the figures are, but we have 1 200 or 1 300 a year killed in road accidents, and we are freaking out. As I said to Mr Denton, that would be wiping out the same number of people as in a town the size of Lakes Entrance in Victoria, which has 6 000 people. It will not be rare. In fact, they said the same thing in Canada, where euthanasia has been legal for two years. They originally gave figures—some of the people who promoted euthanasia—of about 100 cases a year, and in the first year they had 2 000 cases.

Mr R.R. WHITBY: Would it not depend on the type of regime that was adopted in Western Australia, given that we know by example from the law that has been introduced in Victoria that it is very conservative and probably aligns more with the laws that apply in the US, where I understand the rate of euthanasia is much lower?

Prof. SOMERVILLE: I do not think you can hold the rate down once you introduce this. Certainly that is what has happened in Canada, and now they already have committees in Canada looking at, after only two years of the law, extending access to children, people with Alzheimer's disease and people with only mental illness and not physical illness.

They are currently considering that. Belgium has already extended it to children. Children can have euthanasia in the Netherlands. You see, once you look at the rationale for allowing this, it is because people have the right to decide for themselves whether they want to live or die and they want this because they say they are suffering, well then there is no logical stopping point for it. That is the problem.

Mr R.R. WHITBY: Do you agree though that we have not considered in this discussion the number of Australians who take their lives using very traumatic means already?

Prof. SOMERVILLE: Suicide is traumatic? I am sorry; I am having a hard time hearing you.

Mr R.R. WHITBY: The point I was making is that already many Australians take their lives who are facing terminal illness. The proportion of suicide is—I think it is one in seven in Western Australia are attributed to people who are diagnosed with terminal diseases and choose to take their own life in often a very traumatic way. I guess those numbers should be taken into account. I guess those numbers would be quite large across Australia.

Prof. SOMERVILLE: Two things. I am very surprised to hear that terminally ill people in Western Australia are taking their lives, because my understanding—I would want to check this—is that the terminally ill are a group who are least likely to commit suicide. I have forgotten now what I was going to say to you in replying to you. I know: the other thing was that there is research that shows—I am pretty sure this is Dr Harvey Max Chochinov's research—that a group of people asked for euthanasia, I think there were about 50 people in the group, and when they were offered and given good palliative care my recollection is that all but two of them changed their minds about whether they wanted euthanasia. One of the dangers of introducing euthanasia is that you will have a phenomenon of people who are suicidal, who will do what is now being called "death by doctor", which is like the "death by police". That is when people do something because they want to commit suicide, and they put themselves in a situation where they are shot by police. Some people have been writing about this in the literature, that this could also be the reality. I think the main thing you have to realise is what a massive, massive change this is in our fundamental values. It is huge.

The CHAIR: Thank you, professor. We appreciate your time today and the evidence —

Hon NICK GOIRAN: No further questions?

The CHAIR: Have you got a question?

Hon NICK GOIRAN: Yes. Sorry. Professor Somerville, just one question because I sense we have run out of time. On 9 April this year the committee heard from a gentleman by the name of Neil Francis from Dying for Choice. Unlike you, who has 30 minutes, he had probably an hour. Be that as it may, he spent some of his time before the committee commenting about you.

Prof. SOMERVILLE: I am not surprised. He has done lot of that, including, if you look on the ABC Religion and Ethics website you will see a very long dialogue between the two of us.

Hon NICK GOIRAN: Okay. So I do not suppose you would have had an opportunity to read his evidence from 9 April?

Prof. SOMERVILLE: No, I have not. I have not seen the evidence.

Hon NICK GOIRAN: All right. Given we have run out of time and you have not seen it, can I just ask you to take that on notice to read what he had to say about you and you might provide a response in due course?

Prof. SOMERVILLE: Okay. I have written responses to him before. I know what he originally challenged me on was that I made a statement that in all jurisdictions with legalised assisted suicide the general suicide rate has risen. He challenged me on that, and he was correct in challenging me. I should not have used the word "all". I should have said in "most" jurisdictions. Indeed, subsequent to our back and forth on that there is now evidence that the general suicide rate, for example in the Netherlands, has gone up since they have legalised euthanasia. That was the point. It was only on one point that we had the disagreement; he did not challenge anything else in what I had written, certainly at that time.

Hon NICK GOIRAN: Thank you.

The CHAIR: Professor Somerville, thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of transcribing errors only. Any such corrections must be made and the transcript returned within 10 working days from the date of the email attached. If it is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. If you wish to provide clarifying information or elaborate on your evidence, please provide this in an email for consideration by the committee when you return your corrected transcript. We will write to you with any questions taken on notice during the hearing. Again, thank you very much for taking the time to speak to us today, professor.

Prof. SOMERVILLE: Thank you for listening to me.

Hearing concluded at 3.50 pm

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