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
FRIDAY, 9 MARCH 2018

SESSION ONE

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 9.01 am

Mr RICHARD JOHN EGAN
Research officer, Defend Human Life!, examined:

The CHAIR: Good morning, Mr Egan. Thanks for joining us this morning and taking the time to speak to our committee. 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 committee. Shortly to join us will be Mr Simon Millman; we have Hon Dr Sally Talbot; John McGrath; Dr Jeannine Purdy, our principal research officer; Hon Col Holt; Hon Nick Goiran; and Hon Robin Chapple.

The purpose of today's hearing is to discuss the current arrangements for end-of-life choices and to highlight any gaps that may exist. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this does not extend to anything that you say outside of today's proceedings. I advise that the proceedings of this hearing will be broadcast live within Parliament House and via the internet. The audiovisual recording will be available on the committee's website following the hearing. Do you have any questions about your attendance here today?

Mr EGAN: No, I do not.

Hon NICK GOIRAN: Madam Chair, before we get started I will just indicate, because we are in public session, that the witness is known to me. I will just declare what I have already declared to the committee previously, that we used to work together in my electorate office. I confirm we have not conferred in respect to today's evidence.

The CHAIR: Thank you. Before we begin, would you like to make an opening statement?

Mr EGAN: I think that might be helpful, so I will do that, yes.

The CHAIR: Yes; please do.

Mr EGAN: Any law that would permit assisted suicide or euthanasia—whatever euphemism we use to describe those two things—would require a profound change to the longstanding laws on murder and aiding suicide, which currently prohibit intentionally causing the death of any person outside the context of self-defence or capital punishment in some jurisdictions; not ours, of course. It seems to me that the burden of proof is on those advocating for change to establish that such a profound change in the law would be safe for the whole community. I believe that neither the general arguments advanced in favour of such a change nor the evidence from other jurisdictions has established that such a change would be safe. Rather, I think that if you carefully examine the evidence and weigh the arguments, any law that is so far in place that permits either assisted suicide or euthanasia, and the many laws that have been proposed and subsequently rejected by legislatures, you would find that several categories of people would be at risk of dying wrongly. They would include those given a wrong diagnosis; those given a wrong prognosis—we all know people who have outlived their prognosis by many years; those for whom effective treatment may be available but the people signing off on their assisted suicide or euthanasia are not aware of that treatment for various reasons; those who lack access to gold-standard palliative care and therefore are suffering unnecessarily when their suffering could be relieved by means other than ending their lives; people who are denied more expensive treatment by medical insurers, as has happened in Oregon and California in the face of an assisted suicide regime; those who are suffering from

undiagnosed or untreated depression, demoralisation or other mental illnesses; and those who are discriminated against as being better off dead because of social prejudices against people with disabilities. I think there is a whole category of people who could be coerced. When I talk about coercion, I think there is a whole range of it from overt bullying to very subtle coercion—being made to feel a burden on others and therefore choosing to end life prematurely. I think also there is some evidence for people who will commit suicide outside the scheme due to the well-known Werther effect, or the social contagion of suicide. Finally, those who are killed without any request by doctors who have grown used to the practice of ending patients' lives. There were 431 of those in the Netherlands in 2015, the latest year for which we have that data. Some proponents of legalising assisted suicide or euthanasia accept that that is the case. Henry Marsh, a noted British neurosurgeon and champion of assisted suicide, famously said, "Even if a few grannies are bullied into committing suicide, isn't that a price worth paying so that all these other people can die with dignity?" I think that is the question anyone considering this issue needs to ask.

I believe that the proper test for a law permitting assisted suicide or euthanasia is the one that many of you would apply to any proposal to reintroduce capital punishment, perhaps in the light of some horrific new murder, serial killer or rapist or something. That test is: can we craft a law that will ensure there will not be even one wrongful death? I do not believe we can.

The CHAIR: Thank you, Mr Egan. We have had quite a lot of evidence from palliative care specialists who I think are generally in agreement that palliative care is excellent, particularly in metropolitan Perth, and that there have been enormous advances in our ability to manage pain at the end of life. But there are cases—anywhere between, depending on who you talk to, one and five per cent—of people whose pain is really unmanageable at the very end. I understand that you are not a medical practitioner, but for those people with really unbearable pain what are their options?

Mr EGAN: I am certainly not a medical practitioner and I do not want to speak on behalf of medical practitioners. All I can say is that many of the people in the palliative care sphere that I have collaborated with closely over the years in regard to this issue believe that there is always something that can be done. I know you have had a lot of discussion before this inquiry about palliative sedation, and that kind of palliative sedation that is applied when someone is definitely dying and in the last days of life and it is a matter of sedating them in order to deal with otherwise very difficult-to-treat symptoms. There is no ethical problem with that that I can see, as opposed to forms of sedation that are intended to bring about the death of a person. I think, too, looking at some of the figures—I know you have had some discussion around the Palliative Care Outcomes Collaboration.

The CHAIR: Yes.

Mr EGAN: I cannot quote any stats and I could not find the exact charts I was looking for, but I did analyse it a while back, and it is interesting that they are reporting benchmarks across a number of services. What we really should do is look at the results for the best service and then ask, if there is a two to five per cent or whatever figure you come up with who are missing out overall what can we do to get the services that are performing not so well up to the gold standard, best-performing service? Until we have done that, let us not go quoting the figures of people whose pain, fatigue, or whatever the symptom is, are not being relieved because at such and such a place it is not being done quite as well as at the best place in Australia. Let us have a look at that one first.

The bottom line, though, is if you make a law based on a small number of hard cases, unless you can be sure that the law you craft is only going to apply to that small number of hard cases, then you are essentially trading lives. Some people are going to die prematurely—all the ones from those categories I listed—in order to try to relieve the particular pain or difficulty of other people.

[9.10 am]

I would also say—maybe I am moving on to a different question—that I think those arguing for this change operate in what you might call a bait-and-switch argument, where they advance at the start this handful of hard cases of people where we all feel instinctively, "Yes, of course, put them out of their misery." But by the time you have got to the end of the argument they are actually talking about something else. So they are talking about this unrelievable pain or fatigue or these very difficult-to-treat physical symptoms for a handful of people in palliative care, but by the end they are talking about suffering that is defined so broadly that it clearly includes things like the list in the Oregon answers for why people choose assisted suicide: "Less able to participate in enjoyable activities of life". I can expand on that a little more, but I think we have to look out for that bait and switch because that has happened in every case I have seen of a law for assisted suicide being proposed.

Hon COLIN HOLT: Just further to that line of your answering, and this may be a bit premature, but obviously the Victorian Parliament have been through their process and defined some laws. What do you think of those ones and what improvements could occur, from your perspective?

Mr EGAN: Look, I was closely involved with the Victorian debate. I was employed by Dr Rachel Carling-Jenkins, on a casual basis, to assist her with —

Hon COLIN HOLT: And she is an MLC?

Mr EGAN: An Australian Christians MLC; sorry, an Australian Conservatives MLC—I will be in trouble for getting that wrong—in the Victorian upper house. I assisted her and a cross-party group of MPs in analysing the Victorian bill. Look, there was all this talk about 68 safeguards, but when you started unpicking them, as members of the Parliament did in the protracted debate until they were gagged by the Andrews government, they all fell apart. So you are talking about two doctors assessing a person. Only one of them had to have any speciality in the condition, so the other one is kind of a little bit useless really; just a GP who may not have ever treated anyone with that condition. Then for the doctor who had to have the speciality, there is nothing defined around that so you could not even be sure there. There were things like they had to tell the person that palliative care might be available and so on, but the two doctors assessing did not actually have to have any expertise in palliative care or any experience in palliative care, and there certainly was not a referral for a specialist palliative care assessment. So even on the face of it the bill is openly letting people be given an experimental lethal cocktail, which was another big part of the Victorian debate, because you cannot use nembutal legally in Australia for handing over the counter; it is a vet-only medicine. So what was going to be used? Well, some department of pharmacy is going to cook up a formula and we are going to try it out on people and see. They have been doing it in Oregon and Washington since nembutal has ceased being available in the US because of its use in capital punishment. It has been banned. The producers will not let it be exported to the US. For the other drug—secobarbital—the price has gone up and people cannot afford that, so they are just mixing these things together experimentally. The first one they tried, with four different drugs, people were burning their throats.

Hon COLIN HOLT: This is in Oregon, not in Victoria, though?

Mr EGAN: Oregon and Washington. But the relevance to Victoria is that every time an MP asked the Minister for Health or her representative in the upper house what the drug was they were told, "The department of pharmacy is being briefed to come up with the experimental drug." So we are going to actually experiment on this category of people and try out drugs and see how peaceful their death turns out to be. Like I said, in Oregon and Washington the first round of experiments with these new drugs was burning throats. The second round was people taking hours to lose consciousness and hours more to die.

Hon COLIN HOLT: So any suggestion for improvements, because it is there now?

Mr EGAN: Repeal it. That is the improvement I would propose —

Hon COLIN HOLT: That is it?

Mr EGAN: — because there is no model for a safe law. If I go back to that category of people: improve it, get doctors who are never wrong in diagnosis and never wrong in prognosis. Treat all people with disability the same as the rest of us and abolish the idea that a quadriplegic would be better off dead—"I wouldn't want to live like that". When we have dealt with all those things, yes, let us come back and talk about assisted suicide or euthanasia for a small handful of cases. But you cannot mend the Victorian law; it is just too full of dangers and holes.

Hon NICK GOIRAN: Further to this, Mr Egan, the point you have just made about the use of a drug which is controlled by the federal government is an important one. I recall that our terms of reference asks us to look at the implications for any federal law. I do not recall this point having been made before, so thank you for bringing it to our attention. We did have the opportunity yesterday, in a public session via Skype, to meet with some witnesses from DIGNITAS.

Mr EGAN: Yes, the Swiss group.

Hon NICK GOIRAN: Yes. I know, obviously, you have been researching this area of law across jurisdictions for decades. Can you just help us with respect to the Swiss concoction? Would that be something that could be used in Australia under our current laws? Essentially the evidence from the witnesses yesterday was if you have the know-how, there are no problems with their system.

Mr EGAN: I cannot recall exactly what the Swiss are using, so I would have to take that on notice.

The CHAIR: Pentobarbital, and the figure they gave us was that they have assisted in just over 2 500 suicides, and they have had zero adverse effects.

Mr EGAN: Apart from killing Pietro D'Amico, was not terminally ill, if you count that as a—well, it depends whether you are seeing that as collateral damage like Henry Marsh, or you see that as a flaw in the system. I see it as a flaw in the system. He was an Italian who on autopsy afterwards was found not to have the disease he was alleged to have at all, despite two Swiss doctors signing off on it.

Hon NICK GOIRAN: Just back to the pentobarbital. That would be permissible at the moment?

Mr EGAN: No, I think that is on the banned list in Australia.

Hon NICK GOIRAN: So it would be in the same category as nembutal?

Mr EGAN: I think it might be nembutal, but I —

Hon NICK GOIRAN: One and the same?

Mr EGAN: I think pentobarbitone is nembutal. I get them muddled up a bit, so I do not want to say anything that pretends to be authoritative, but I think pentobarbitone is nembutal, and then there is secobarbitol and—yes.

The CHAIR: Mr Egan, could the same mistake be made in relation to terminal sedation?

Mr EGAN: Palliative sedation of the kind I am talking about as ethically unproblematic is where someone is in the last days of life. I think from the evidence I have seen that this committee has already been given by palliative care experts, the consensus is that as you get closer to the end of life the prognosis gets sharp. Look, nothing is completely free from error, so theoretically you could have someone who looks exactly like they are going to die in a day or two but something has been missed. That is possible. But I think in that kind of setting it is much more likely that they are going to be getting it right a much higher percentage of the time, and palliative sedation, of course, is not designed to kill. Palliative sedation is designed to put someone into a sedated state so that they are

not experiencing the symptoms, so you are not actually killing them. So if you did get it wrong and they were still alive a week later, you would bring them out of the sedation and do some more tests and find out what was going on and how come they were not dead when you thought they were going to be. So, no, I do not think the same thing does apply.

[9.20 am]

The CHAIR: What is your position on an individual's right to withdraw from life-sustaining treatment and food and hydration?

Mr EGAN: Legally, no-one can be treated or even fed by hand if they are in their right mind and competent and they say no, because that would be a trespass on the person. The ethical question is an entirely separate one: what decision should we make about our medical treatment? But the legal question I think is crystal clear: no-one can treat someone without their consent unless there is a question of competency.

The CHAIR: Do you agree with the treatment of withdrawal of hydration and nutrition as part of palliative sedation? We have had quite a bit of evidence that that combination is used.

Mr EGAN: The only reason to stop feeding or hydrating someone is because physically they cannot absorb it, or they have completely lost appetite and interest. Again, I think the evidence you have had from palliative care specialists already to this inquiry was very clear on that point and distinguishes the two scenarios of natural loss of interest in food and hydration towards the end of life. The idea that someone who is not imminently dying would be sedated and then not fed really is a way of potentially killing that person, and that should not be conflated with the circumstance of someone who at the end of life loses the capacity or the interest in food.

The CHAIR: It sounds as though you have been following some of the evidence before the committee.

Mr EGAN: Yes; everything that has been published so far I have had a chance to read.

The CHAIR: Have you had an opportunity to look at the evidence from the MND WA association?

Mr EGAN: I did, yes.

The CHAIR: There was quite an upsetting case study, if you like, that the neurologist, Dr Edis, provided of a young woman who elected to starve herself, and that is currently under the legal framework allowed, but she probably would have had at least weeks to live. Those medical practitioners in the hospice supported her in that decision, albeit it was difficult to find the environment that enabled her to exercise her own choice. Can I ask you to make comment on that?

Mr EGAN: I would not want to, because she is a named individual with a very specific case and I do not have any medical qualifications, so I really would prefer to handball that question to any medical witness you have before you. I think it is just too specific for me to answer.

The CHAIR: Sure. You mentioned in your statement and in your submission the contagion of suicide. Can you just elaborate on that for us?

Mr EGAN: Sure. It is called the Werther effect, after *The Sorrows of Young Werther*, a Goethe novel which, when that was published, romanticised the suicide of a young man who was disappointed in love—as some of us are from time to time—and there was a spate of suicides following the publication of the book. The phenomenon has been called the Werther effect, and there have been sociological studies on it which establish that when suicide is publicised, it leads to a spate of suicides, often using the same method, but not necessarily so. There is some anecdotal evidence about—her name escapes me—Brittany Maynard, the young American woman who became the poster girl for Compassion & Choices. There is certainly anecdotal evidence internationally of, I

think, a case in Costa Rica of a young girl with cerebral palsy who was watching the Brittany Maynard appeals on You Tube and so on and was starting to plan her own suicide because of Brittany Maynard, until someone intervened and gave her some help, fortunately, in that case.

There is a study by David Patton and David Albert Jones, which as far as I can make out is the only peer-reviewed study on this question. It came to the conclusion that if you put together assisted suicides and suicides, that in the US states where assisted suicide has been legalised, there is an excess of 16.5 per cent suicides in the 65-plus age bracket, if you are counting both assisted suicides and suicides, and there is no decrease in the suicides that are not covered by the assisted suicide law. That was an important study, because one of the arguments that you have had put to your committee and is put by proponents of this bill is that if we are going to stop the kinds of suicides the coroner was talking to you about by allowing assisted suicide, we are going to overall reduce the suicide rate, because some people will keep this lethal medication in their cupboard and will take it and so on. So the hypothesis was that assisted suicide will actually decrease the suicide rate among the target population. The Patton–Jones study shows decisively that that is not the case. The data did show an increase in the suicide rate apart from legal assisted suicides, but it was not sufficiently robust for them to say that is statistically significant. They were very modest in their claims. Patton is an actuary scientist, so he knows how to deal with data of this kind, and it is a very rigorous study. I think that is something we have to bear in mind.

In Victoria, this came up in the debate a lot. If you look at your state's suicide prevention study or framework—I forget what it is called here in Western Australia at the moment—the target is to tell everybody that there is a better way, that there is hope. An assisted suicide scheme wants to bracket off a whole category of people and say suicide prevention for most Western Australians, and suicide facilitation, by law, for some other Western Australians. How are you making that distinction? Of course, the broader your assisted suicide law that is passed, the more that distinction is sort of harder to sustain, and the messages that are then sent out to the community. If you take the Philip Nitschke line, for example, he wants the means of suicide to be available to everybody, including the depressed and the troubled teenager—that is his *National Review* online quote. I mean, he has got it right in a sense, that if we are going to give the message that anyone in our community can decide, "Life is too hard; it's not worth living; give me the means to kill myself", who are we to say that the elderly person with cancer is entitled to say that, but the teenager who failed in his exams and his girlfriend has dumped him is not allowed to say that? What is the basis? I have not heard a persuasive putting of the case as to what is the distinction between those two messages.

Hon Dr SALLY TALBOT: Mr Egan, if I was following your argument, then, are you suggesting that under the Victorian legislation, the teenager who fails his exams and is dumped by his girlfriend could have access to euthanasia?

Mr EGAN: No, I am not. I must not have made myself clear, Dr Talbot. I was talking in the context of the suicide contagion effect.

Hon Dr SALLY TALBOT: Okay. So you are talking about the slippery slope?

Mr EGAN: No, it is not the slippery slope. It is a scientific phenomenon called suicide contagion, or the Werther effect, which shows that where suicides are presented in any positive kind of light, there is an increase in suicides through copycat or through other methods by people who are not the target of the message nonetheless absorbing the message and acting on it.

Hon Dr SALLY TALBOT: So is it your view that voluntary assisted dying—as the Chair has noted, you are familiar with all the evidence we have received—are you suggesting that is the same thing as a suicide in the broader context?

Mr EGAN: Yes. If a person is given, as under the Victorian scheme, a dose of lethal medication to take home and keep in their bathroom cupboard to be taken at some point, and takes that medication with the intention of causing their death—the Victorian legislation dozens of times talks about "intending to cause death", and the whole point of the prescription for lethal medication is for a drug that will immediately cause a person's death. So, yes, obviously physically the act is exactly the same, and in terms of how the act is perceived by most ordinary people, it is exactly the same.

Hon Dr SALLY TALBOT: Do you think most ordinary people would think that they were the same—that both constituted suicide?

Mr EGAN: Yes. I think most people understand that suicide is intentionally ending one's own life.

Hon Dr SALLY TALBOT: As you know, because you are a very experienced witness in this and many other fields, the purpose of a hearing like this is so that we can begin to understand what your views are based on. In your mind, is there a difference?

[9.30 am]

Mr EGAN: No; I do not believe there is a difference in the act of suicide; it is exactly the same act. The means will not be exactly the same.

Hon Dr SALLY TALBOT: That scenario you have just given us, albeit hypothetical, and you have already said it would not be covered by the Victorian laws, in your mind they are the same thing. The teenager who commits suicide because he has failed his exams and lost his girlfriend.

Mr EGAN: Let me say that every suicide is an individual story and I would not want to conflate any one suicide with another because they are all individual tragedies. Returning to my list of categories at the beginning of people whose lives may be ended prematurely by an assisted suicide law, if a person who was wrongly diagnosed or had a wrong prognosis or was missing out on palliative care because they were not getting the gold-standard palliative care and who is given instead a lethal drug to end their life, that suicide is tragic just as the suicide of a depressed middle-aged man who has lost the family farm or a teenager who commits suicide is tragic. If you want to do a quality of years lost, maybe less years are lost to the community from a suicide later in life but it is equally a tragedy. I do not think we can put out a mixed message on this. Members tried to press the Minister for Health on this in the Victorian Parliament: What is Lifeline going to be told? If someone calls up saying, "I'm feeling suicidal", do they first ask, "Well could I check whether you have a diagnosis of a terminal illness that gives you less than six months to live; yes or no? If the answer is yes, let me refer you to the Western Australian government assisted suicide facilitation line."

Hon Dr SALLY TALBOT: Have you asked Lifeline?

Mr EGAN: I have not asked Lifeline myself, but members of Parliament did try to probe this question in Victoria, but were certainly not to my mind given satisfactory answers, because we would be introducing a double standard. We would be saying that some lives, the message is clear, do not commit suicide. Let us help you, let us find another way. For another set of people, we are going to say, "If you go to these doctors and if you fill out these forms"—in Victoria it was actually the state which would issue a permit—"here is your voluntary assisted dying self-administration permit stamped by the Victorian government, now you go and get your lethal prescription and take it home and take it possibly alone with no-one there, no requirement for a witness under the Victorian law or under Oregon or Washington State law, so people are dying alone at home, some of them having seizures, some regurgitating, some of them going into comas for hours. It is not the peaceful death that is promised by proponents.

Hon Dr SALLY TALBOT: You might almost see that as a bonus point in the Swiss system, mind you?

Mr EGAN: Alongside them killing people who are not terminally ill because they do not know what they are doing.

The CHAIR: Just following from this, would you consider refusal of lifesaving treatment to be suicide?

Mr EGAN: Are you asking a legal or ethical question because they are different answers I suppose.

The CHAIR: In your opinion.

Mr EGAN: Sure. Ethically, if you refuse simple, effective lifesaving treatment and you are not otherwise dying, that could be a form of suicide. For example, if I am a diabetic, I am insulin dependent and I want to commit suicide, going back to the teenager, because my girlfriend dumped me and I am failing my exams and I stopped taking insulin, I think, ethically, from some perspectives, we all see that as a form of suicide. You have deliberately ended your life.

To return to the legal point though, people have a right to refuse treatment because to impose treatment on someone without their consent is to trespass on the person and we cannot do that. I cannot recall the law in WA but in some states there is a law that allows you to stop the person jumping off a bridge, for example. I think in WA there are some similar laws. Even in the advance directive—there is a provision not to apply the advance directive in the case of a suicide attempt.

The CHAIR: Given that the current legal framework allows for someone to refuse treatment, would that naturally, in your view, promote suicide in the community under the suicide contagion theory?

Mr EGAN: No, because refusal of medical treatment has many legitimate purposes. They are quite distinct from suicide. Suicide by refusal of treatment will be a rare thing. Most people who are refusing treatment are just saying, "I don't want the next round of chemo because I've weighed up the risks and benefits." It is part of ordinary, everyday life. We all make decisions about what to spend our money on in terms of health treatment and that will weigh up a whole number of factors, including the economics of it, the risks and benefits that the doctor has explained to you, what your priorities are in life and so on. I do not think at all the same message is sent by that.

The CHAIR: Do you think that doctors rely on the doctrine of double effect in palliative care?

Mr EGAN: It was fascinating reading the discussion on this because, essentially, double effect is something we all live with every day. Everything we do has the consequence we are intending and aiming for. It also has other consequences. My understanding of the doctrine of double effect is that it simply means you can do something even though you know it will have some bad consequences provided the thing you are actually intending to do is itself good and proportional to the bad effect you are going to have. Doctors use this every time they perform surgery. Every surgery carries the risk of a patient dying under anaesthetic or cutting the wrong artery or doing something like that, so double effect is used right across everyday life and medicine. I think it has become this sort of abstruse thing somehow in the context of end-of-life care that is unnecessary. I am also very aware of the most recent studies from palliative care that show the old school of thought that giving appropriate morphine and other opiates for pain relief at the end of life runs the risk of shortening life is almost certainly not the case and, in fact, relieving people's pain adequately tends to, if anything, prolong their life. But, again, I am not a medico so I accept the studies on that.

The CHAIR: Do you think that the current legal framework protects doctors in relation to double effect and administration of potentially life-ending medications?

Mr EGAN: Yes. I think again the best evidence you have had on this is that if anything is needed, it is some better education of doctors as to what the law actually does provide. If it is the case that doctors are not giving adequate pain relief because they are undereducated either about medicine

or the law, then the answer to that is we just need to educate them. But no, my understanding is there is no real risk that a doctor acting properly in that area could be convicted of any crime under Western Australian law.

The CHAIR: Do we have any further questions for the witness?

Mr EGAN: I did want to say something about the coroner's evidence if I get a chance, but I am happy to take questions.

Hon NICK GOIRAN: Mr Egan, you are probably one of the first witnesses to provide us with a comprehensive list of individuals who would be at risk in the event that Western Australia legalised physician-assisted suicide. I heard you list 10 things but I have a record of only nine of them. You talked about a person who would be misdiagnosed where the prognosis is wrong; the treatment that might be available that the doctor is not even aware of; the person who does not have access to the gold-standard palliative care; the person is denied by way of their insurer; the person subject to mental illness, including demoralisation; those who are subject to disability discrimination; the person subject to coercion, both overt and subtle; and the person who might succumb to suicide contagion. That is nine.

Mr EGAN: Yes, my last was: if we allow assisted suicide, particularly euthanasia, I think more so, euthanasia involves a doctor actively killing his or her patient and I do not think we should underestimate what that does to the wellbeing and the psychology of the doctor. I do not know whether you are familiar with studies in a different area, the area of war, but there was a famous paper that studied the reluctance of soldiers in the First World War and I think also the second to actually shoot directly at the enemy despite their basic military training.

[9.40 am]

It is hardwired into us that we do not kill each other. A doctor particularly, who has been trained to care for people—even Nitschke talks about how he felt after the first people he killed, and he is passionate, he believes he is doing the right thing. There certainly have been doctors in the Netherlands who did some euthanasias and then stopped. It is a very hard thing that we ask doctors to do if we make a law defending euthanasia. But some doctors will push through that change in the brain's hardwiring, just as in the Vietnam War they learnt a new method of training soldiers to shoot directly at the enemy. It involved something very similar to point-and-shoot video games, which is another area of interest. It breaks down that barrier. A doctor who is repeatedly giving lethal injections to patients and seeing the patients die in front of them becomes inured to that. I am not blaming them if that is the legal system and they do it, but that happens to them. It is not surprising then that in 2015, in the next round of five-year detailed studies, they found that there were 431 people killed in the Netherlands by direct action by a doctor with the explicit intention of ending their life—no request. That's the tenth category, Mr Goiran.

Hon NICK GOIRAN: The other thing I wanted to ask you is: you have helpfully set out some information with respect to the Victorian legislation. That does not come into effect, I do not think, until next year.

Mr EGAN: On 19 June 2019.

Hon NICK GOIRAN: So we do not have any actual lived experience of Victoria, but have you ever had cause to review the Northern Territory situation?

Mr EGAN: Yes, and I think there are several extracts from my analysis of that in the Defend Human Life! submission. The definitive papers on that are *The Lancet* article and the chapter in a book, co-authored by David Kissane. I could say that the ad hominem attacks on some opponents of this law by proponents is extraordinary. Andrew Denton's submission "Go Gently " carrying on about David

Kissane, a professor of psychiatry at Melbourne University and a highly respected academic. "Oh my God! He's a knight of Malta! God forbid!"—part of an order that has been nursing the sick for 900 years and how dare he be coming into the public debate on a question of his actual expertise, which is psychiatry and palliative care at the end of life—"My God! He's a knight of Malta, shock, horror!" I really find it quite frightful this ad hominem attack on a man of his standing and integrity, but that is the Andrew Denton approach. Sorry, I digressed and may have missed the question.

Hon NICK GOIRAN: That is all right. You mentioned Kissane, did he give evidence in Victoria?

Mr EGAN: Yes—I cannot recall whether he gave evidence; he certainly gave some briefings to members of Parliament. He has given evidence to commonwealth parliamentary inquiries into various federal assisted suicide proposals. One of those—yes, he certainly gave evidence on the Northern Territory experience. To sum up the Northern Territory experience, of the four cases, there were serious doubts about mental illness, depression, even though the Northern Territory is one of the few jurisdictions that ever required an assessment by a psychiatrist, but the psychiatrists' assessments were Monty Pythonesque, to say the least. Nitschke, in evidence before a Senate committee, describes taking this gentleman into see a psychiatrist: Nitschke himself paying the bill for the psychiatrist; Nitschke creating a fuss in the room that the man had to fill out a form to become a patient of the psychiatrist to get the examination, and saying, on Nitschke's own evidence, "He's going to be dead in a few hours. Why does he have to fill out the form?"; and, the psychiatrist seeing him for less than 20 minutes and signing off on him, not having any condition that would affect his competence to choose assisted suicide. So I think the Kissane study, of which, of course, Nitschke was a co-author of *The Lancet* article, shows the flaws in the Northern Territory scheme, which, in fact, had more safeguards than most of the schemes proposed since, including compulsory referral. It also had a requirement for a specialist. In one case a cancer was signed off on by an orthopaedic surgeon who had no qualifications in the cancer area, and that was never investigated. So the Northern Territory safeguards, even that small dataset of four deaths, was riddled with holes.

Hon NICK GOIRAN: If the committee wants to know about the Northern Territory experience, Kissane is the guy to talk to?

Mr EGAN: Kissane is an expert.

Hon COLIN HOLT: I am really interested in what you said a minute ago about the Northern Territory safeguards. In your opinion, after looking at all the systems and legislation that has been introduced into the jurisdictions, which one has the most safeguards?

Mr EGAN: Some have attempts at some sort of safeguards and some have attempts at others. For example, you can look at the two —

Hon COLIN HOLT: But you cannot compare them, apples with apples?

Mr EGAN: I think that they are hard to compare. Some of the ones that have euthanasia, you might think there are more safeguards because you do not have the problem of the lethal medication sitting in the bathroom cupboard at home; the lack of a witness. So one of the big concerns with Oregon is everyone says that Oregon is safe—all the proponents say Oregon is safe—but we do not know because the medication is actually taken alone at home. You really do not know if someone else forced it down their mouth. There is simply no evidence for this because there is no witness there, so we do not know that. We do not know if when someone takes it two years after they were prescribed it, they have lost competency in the —

Hon COLIN HOLT: Maybe I can put the question in a different way: if you were a citizen of one of those jurisdictions, which one provides the greatest safeguards for you for not being caught up in a

voluntary assisted dying scheme or a euthanasia scheme? Where would you rather be if you were one of the ones —

Mr EGAN: I think in the Netherlands there are doctors killing people without them even asking for it, so I think there is a particular risk in euthanasia schemes that some doctors become inured to killing their patients and do so without a request. I think that is a pretty big flaw in a system. On the other hand, if I was in Oregon or somewhere and on first being told I had cancer and six months to live and feeling the natural depression that might come with that I went to a Compassion and Choices doctor, I could be dead within 10 days without having any chance to explore real treatment options or to get some treatment for my depression. I honestly think that in any jurisdiction where the state approves a scheme for the killing of its citizens, all of that category of people is at risk, except the last one would only apply in a jurisdiction that allowed direct injection euthanasia.

Hon ROBIN CHAPPLE: A final question, Mr Egan. I presume that at some stage you reviewed the two pieces of legislation I put in.

Mr EGAN: Yes, indeed.

Hon ROBIN CHAPPLE: What was your view of those compared with others?

Mr EGAN: To be honest, Mr Chapple, with respect, I cannot remember the details of them, but my overall impression at the time would have been that they had similar flaws to the legislation in other places.

Is there time for me to comment briefly on the coroner's evidence?

The CHAIR: Yes. We have a couple of minutes left, do you want to talk about that?

Mr EGAN: That would be excellent. I wanted to do this because it played a big role in Victoria, and I think the evidence before you is a little bit different. The evidence before the Victorian committee from the coroner was that there were this set of suicides of people with either a terminal illness or a physically deteriorating condition, and that second part got confused into the terminal illness and by the time the minister for health was quoting the stat in the Parliament, it was one Victorian with a terminal illness was committing suicide per week, which when you drilled down into the data was not the case—at most she had doubled the rate because half the people had physically deteriorating conditions, they were not terminally ill. I think the most perverse thing that the coroner did was to make what I found to be an absolutely outrageous and appalling claim—and I am prepared to say that—that nothing could have been done in any of these cases except for offering assisted suicide. The coroner presented some case studies. One of the case studies was about an elderly woman who was losing her sight. She ended up slitting her wrists and bleeding to death in the bathroom. When you read that story and you think that if the coroner is right and the only alternatives are to leave her bleeding to death with slit wrists in the bathroom or to give her a lethal drug to take home and take alone by herself in the bathroom and die by herself, maybe the medication is a little bit messier than bleeding to death.

But when you drilled down in the case study, what was her big concern?—"I can't read anymore", she tells her neighbour. I am looking at this and thinking, "Did anyone talk about audio books? Did anyone contact the local library? Did anyone suggest someone coming and reading to her?" When you looked at the case studies, the problems were not terminal illness—that was going on—but social isolation, loss of some particular ability and not being given the help that society ought to be offering to people in those things. To say as the coroner said that there is nothing else that we can do—the evidence before your committee, you have this data set from the national coronial inquiry service and if you break that down, I think the category of terminally ill with a downturn in health comes out at about 48 over the period, which I think was 9.6 a year so 10 a year. I just encourage

you not to jump from thinking that here are these 10 people who tragically asphyxiated themselves, took some other medication or shot themselves to say that because they committed suicide, that was inevitable and there was nothing else that could have been done so let us have the state approve their suicide so that instead of 10 suicides that we all say are tragedies, it is now going to be 10 suicides that we all say are approved by the state. I do not think it is that simple. You would have to look at each of those cases and really examine whether the person was getting the best palliative care. Were family supports in place and if there were not family supports, what was society doing to step up and meet the gap? Let us not rush too quickly to say from the coronial data set—I am pleased that from everything I have read, your coroner is certainly not taking the same kind of advocacy line, but in Victoria that won votes for the bill and it was on the basis of fallacious interpretation of a data set and an outrageous claim that nothing else could be done.

The CHAIR: Thank you, Mr Egan, for your evidence before the committee today. A transcript of this hearing will be forwarded to you for the correction of minor errors. Any such corrections must be made and the transcript returned within 10 working days from the date of the email attached to the transcript. If the transcript 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 of evidence. Thank you very much for taking the time to speak to us today, Mr Egan.

Mr EGAN: Thank you very much for your questions.

Hearing concluded at 9.52 am