EOLC Sub 567
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Dear Dr Purdy

SUBMISSION TO SELECT COMMITTEE ON END OF LIFE CHOICES

1. BACKGROUND

From 1997 to 2010 I had the privilege of managing a funding program called Innovative Health Services for Homeless Youth (IHSHY), among other responsibilities, while working for the Western Australian Department of Health, latterly as Senior Policy Officer for At Risk Youth. I have also worked in a number of positions concerning aged care and care for people with disabilities, including Senior Contract Officer and Manager, Aged Care Programs.

I have lost a close family member to suicide.

The opinions in this submission are mine and not those of my former employer the Department of Health, or my government or non-government colleagues.

This submission primarily addresses Term of Reference (c), "consider what type of legislative change may be required, including an examination of any federal laws that may impact such legislation." It focusses on the question of legislative change to allow for euthanasia or assisted dying in particular circumstances. I shall set out firstly some general considerations and secondly some specific issues relating to euthanasia and assisted dying as end of life choices.

2. GENERAL CONSIDERATIONS

While it is impossible not to sympathise with the case for relieving the suffering of people with distressing terminal conditions, looking at the broader picture reveals serious and unacceptable risks.

There is an alarmingly high incidence of mental health problems and suicide among children and young people.

The 2013-14 survey conducted by the Telethon Kids Institute in partnership with Roy Morgan Research found that one in seven children and young people experienced a mental disorder in the previous 12 months—the equivalent of 560,000 young Australians (Australian Government, *The Mental Health of Children and Adolescents: Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing*). An inquiry conducted in Western Australia found that one in six children and young people between the ages of four and 17 years in that State experiences a mental health problem (Commissioner for Children and Young People, *Report of the Inquiry into the mental health and wellbeing of children and young people in Western Australia*).

Depression is also common among elderly people. According to Beyond Blue:

> Depression is common throughout the Australian population, and older people are more likely to experience contributing factors such as physical illness or personal loss.
>
> It is thought that between 10 and 15 per cent of older people experience depression and about 10 per cent experience anxiety. Rates of depression among people living in residential aged-care are believed to be much higher, at around 35 per cent.

> Unfortunately, many people over 65 still seem to feel there is a stigma attached to depression and anxiety, viewing them as weaknesses or character flaws rather than a genuine health condition.
>
> Older people are also more hesitant to share their experiences of anxiety and depression with others, often ignoring symptoms over long periods of time and only seeking professional help when things reach a crisis point.
>
> (https://www.beyondblue.org.au/who-does-it-affect/older-people/starts-at-sixty)

In these circumstances, the mooted introduction of euthanasia or assisted dying risks countering the efforts of suicide prevention advocates and services and sending a strong—though unintended—message that suicide is an acceptable way out of circumstances that are felt to be severely mentally or physically painful. It risks this especially for members of vulnerable groups—at risk young people, people with mental illnesses, the frail aged.

3. SPECIFIC ISSUES

As the Committee will doubtless be aware, experience in jurisdictions where euthanasia or assisted dying have been introduced makes it clear that there is a very high risk of its application being extended beyond people with painful terminal conditions. There is also a risk that people who do have painful terminal conditions will be motivated to seek euthanasia or assisted dying because of accompanying non-physical conditions such as depression.

According to a recent study in the *Medical Journal of Australia*:

> when researchers from the Netherlands — who were convinced that the main rationale was pain — interviewed patients who requested euthanasia, they found that few of the ones using euthanasia were experiencing pain, but most were depressed.
>
> The importance of psychological suffering as patients' rationale for requesting euthanasia and PAS [Physician Assisted Dying] indicates that these interventions are less like palliative care and more like traditional suicide condoned and assisted by the medical community. The main drivers of traditional suicide are psychological problems.

(Ezekiel Emmanuel, Euthanasia and physician-assisted suicide: focus on the data. *Medical Journal of Australia* 2017; 206 (8): 339-340. || doi: 10.5694/mja16.00132)

Additionally, depression is often not correctly diagnosed in older people:

> For example, older people are less likely to display affective symptoms, e.g. dysphoria, worthlessness and guilt, and more likely to show cognitive changes, somatic symptoms, e.g. sleep disturbance, agitation and general loss of interest.1 These symptoms and their patterns of presentation can be attributed to other disorders and this often presents a challenge in differential diagnosis.
>
> (*Best Practice Journal* Special Issue: Depression in Older Adults (2011), page 3. https://bpac.org.nz/BPJ/2011/July/docs/bpjse_elderly_depression_2011.pdf)

It should also be noted that the principal instruments used in the clinical diagnosis of depression take the form of interviews and questionnaires. These are inevitably limited and may be especially so in care situations:

> Diagnosis can be very difficult in practice. The medical ward is often noisy with little privacy and ward routines may be obtrusive making it difficult for the psychiatrist to find a suitable time to see the patient. Patients may be dysarthric [experience speech difficulties] or deaf, and they may be too ill to be moved to an interview room or other quiet and private situation. They may be fatigued by their illness or by its investigation, and they may be sedated and/or confused by prescribed medication.
>
> (Mavis Evans and Pat Mottram, Diagnosis of depression in elderly patients. *Advances in Psychiatric Treatment* Jan 2000, 6 (1) 49-56; DOI:10.1192/apt.6.1.49)

In particular, suicide and suicidal ideation are not uncommon among elderly patients and can also be hard to recognise.

> Feelings of life not being worth living and wishing to die can occur in the absence of depressed mood. (Other factors linked with the wish to die include not being married, poor subjective health, disability, pain, sensory impairment and living in a nursing home or hostel.
> Fleeting suicidal thoughts are common in the elderly, especially those who are physically ill or disabled. Suicide itself is not rare – age and physical disease being known risk factors for suicide. Coroners' figures are probably an under-estimate as not all suicides in this group are active: non-compliance with medication for physical conditions can lead to death from ‘natural causes’.
>
> (Mavis Evans and Pat Mottram, Diagnosis of depression in elderly patients. *Advances in Psychiatric Treatment* Jan 2000, 6(1) 49-56; DOI:10.1192/apt.6.1.49)

Given this, it is clear that there is a considerable risk of euthanasia or assisted dying being carried out in patients who are in reality depressed or otherwise disturbed, and who could instead have been supported to improve their mental health.

It will be argued that safeguards can be established to manage these risks. Against this it should be considered, firstly, that many doctors and health care professionals will decline to take part

in euthanasia or assisted dying. Consequently, decisions on who is to be given access to euthanasia or assisted dying are likely to rest with doctors and health care professionals who are already favourably disposed to them.

Further, in these circumstances there is a great risk of "mission creep." If you have carried out or facilitated euthanasia once, there is a strong incentive to see it as a good thing, and so to be more likely to participate in it again; possibly in less extreme circumstances. As an instance of this, consider the career of euthanasia advocate Dr Philp Nitschke. Dr Nitschke has now reached the stage of advocating access to euthanasia for all adults, medically unwell or not (https://www.theguardian.com/australia-news/2016/dec/04/philip-nitschke-launches-militant-campaign-for-unrestricted-adult-access-to-peaceful-death).

Dr Nitschke's is doubtless an extreme case. But the risk of gradual extension of the coverage of euthanasia and assisted dying is real and is exemplified by recent reports of euthanasia being carried out on mentally ill people in Belgium and the Netherlands. I cite a report in the UK *Telegraph*:

> The Netherlands has seen a sharp increase in the number of people choosing to end their own lives due to mental health problems such as trauma caused by sexual abuse.
>
> Whereas just two people had themselves euthanised in the country in 2010 due to an "insufferable" mental illness, 56 people did so last year, a trend which sparked concern among ethicists.
>
> In one controversial case, a sexual abuse victim in her 20s was allowed to go ahead with the procedure as she was suffering from "incurable" PTSD, according to the Dutch Euthanasia Commission.
>
> But a Dutch psychiatrist who has carried out euthanasia requests at the country's End-of-Life clinic said this week that psychiatrists are "too hesitant" about agreeing to euthanasia for patients with psychiatric diseases.
>
> Paulan Stärcke, who will present her findings at the Euthanasia 2016 conference in Amsterdam Thursday, told The Telegraph that even children as young as 12 who ask to end their lives should be taken seriously.
>
> (http://www.telegraph.co.uk/news/2016/05/11/netherlands-sees-sharp-increase-in-people-choosing-euthanasia-du/)

As a bare minimum, if euthanasia or assisted dying are proposed for Western Australia, it should be with full awareness and acknowledgment of the unintended consequences that are

highly likely to follow, in some cases tragically. Where this happens, the results should be clearly understood:

- Firstly, someone will have been euthanised or assisted to die who need not and should not have died.
- Secondly, one or more health care professionals will have "euthanised" or assisted to die someone who need not have died. (Here "euthanasia," a good, easy or happy death, is clearly not the right term for someone who should not have died.)
- Thirdly, the State Government will have enabled the death of an individual who should not have died.

If the high risk of these and other unintended negative consequences, falling mostly on highly vulnerable people, is judged to be an acceptable price to pay, this should be explicitly stated and understood. I believe it is not acceptable.

4. CONCLUSION

I conclude with a further general consideration, which the specific issues noted above will reinforce.

It is one thing to say "Person x *should be allowed* y." It is quite another thing to ask *by whom* and *with what mechanism* it should be decided who is to be allowed y.

Governments make decisions on matters of life and death routinely. They decide to go to war or not to go to war. They decide to fund this life-saving drug and not that one; to repair one road before another; to fund or not to fund services that would support at risk groups.

But they do not at present make decisions as to which named individual persons should live or die. To do so is to take a profoundly dangerous step. It is on the one hand to promote the idea, and indeed the reality, of human life as disposable; and on the other hand to give the State the power of life and death over particular individuals.

I urge the Committee to investigate fully options for improving and extending palliative care, home and community care and mental health services for people with terminal or hard to treat physical and mental health conditions, and to resist calls for euthanasia and assisted dying in Western Australia.

Michael Robinson

23 October 2017