CATEGORIES OF WRONGFUL DEATHS BY ASSISTED SUICIDE AND EUTHANASIA- PART 1

RICHARD EGAN

INTRODUCTION

A careful examination of the evidence from those jurisdictions that have laws permitting either assisted suicide or euthanasia shows that at least twelve categories of people would be at risk of wrongful deaths.

Some proponents of legalising assisted suicide or euthanasia admit that it is the case that wrongful deaths will occur.

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?"

This is the question that anyone considering this issue needs to ask. The proper tests for a law permitting assisted suicide or euthanasia are the ones that are usually applied to any proposal to reintroduce capital punishment:

"Can we craft a law that will ensure there will not be even one wrongful death?" "Can we ensure that any deaths under this law are humane - that is both rapid and peaceful?" Both simple logic and the available evidence show that neither of these outcomes are achievable.

A WRONG DIAGNOSIS

If a person dies by assisted suicide or euthanasia following a mistaken diagnosis that the person has a terminal illness then that is a wrongful death – with no remedy.

According to evidence given by Dr Stephen Child, Chair of the New Zealand Medical Association to the New Zealand parliamentary inquiry into the practice of euthanasia: "On diagnosis, 10 to 15 per cent of autopsies show that the diagnosis was incorrect. Three per cent of diagnoses of cancer are incorrect"[1]. Dr Child said this scope for error was too large, when weighed against the outcome.

"This is an irreversible decision in which the consequences are final."[1] Ten per cent of cases in Australia are misdiagnosed according to Peter McClennan, chief executive at Best Doctors.[2]

Simply having two doctors diagnose that a person has a terminal illness is an illusory safeguard. There is no remedy for a wrongful death by assisted suicide based on misdiagnosis. How many wrongful deaths from assisted suicide following misdiagnosis of a terminal illness are too many?

1 https://www.stuff.co.nz/national/politics/84252580/euthanasia-too-final-when-the-risk-of-error-is-too-great-doctors

2 https://amp.afr.com/business/insurance/insurance-companies/mlc-life-to-expand-best-doctors-service-20170827-gy4zfk

A WRONG PROGNOSIS

If a person dies by assisted suicide or euthanasia after being told in error that they have less than six months to live when they may have many years of life ahead of them then that is a wrongful death – with no remedy. The finding in 17% of cases physicians were overly pessimistic in their prognosis by more than 33% and out by a factor of 2 in 11.3% of cases is directly relevant to the use of a prognosis as an eligibilty criterion for access to assisted suicide or euthanasia[3]. In other words, perhaps more than one in ten people given a prognosis of 12 months to live may live for 2 years or more.

UNAWARE OF AVAILABLE TREATMENT

Some assisted suicide or euthanasia laws purport to provide an additional safeguard by requiring at least one doctor with relevant specialist experience to assess the person and inform them of all relevant information about the person's condition. However, despite such provisions the evidence from jurisdictions which have legalised assisted suicide or euthanasia shows that some people miss out on treatment that could have helped them and instead suffer a wrongful death by assisted suicide or euthanasia.

NO ACCESS TO PALLIATIVE CARE

There is a telling disconnect between the focus of assisted suicide and euthanasia laws when they are being proposed and after they have been implemented. During the proposal phase the focus is almost universally on an alleged group of hard cases, few in number, who, it is said, are suffering unbearable physical pain or other physical symptoms that cannot be relieved by even the best palliative care. This claim is based largely on anecdotal evidence, often from earlier decades before recent improvements in palliative care.

After implementation it becomes clearer that the real focus is on autonomy – an alleged right to assistance to die at a time of one's own choosing for any reason.

KILLED WITHOUT REQUEST (OR WHILE RESISTING)

Those who are killed without any request by doctors who have grown used to the practice of ending their patients' lives are clearly wrongful deaths. In some cases a doctor has performed euthanasia even where a person resisted.

DENIED FUNDING FOR MEDICAL TREATMENT

People who are denied funding for medical treatment by medical insurers or the public health system but are offered funding for assisted suicide or euthanasia, as has happened in Oregon, California and Canada are at risk of wrongful deaths either by being denied needed treatment or bullied into agreeing to assisted suicide.

CONCLUSION

Legalising assisted suicide or euthanasia crosses a serious ethical 'line in the sand' with serious consequences for patients and the practice of medicine. It is not progressive, but a regression to a poorer standard of medicine, focused on quick solutions and convenience.

Changing the laws to permit assisted suicide or euthanasia is unnecessary, unsafe, unfair, and ill-informed.

This article outlines just six categories of wrongful deaths which have occurred in jurisdictions where assisted suicide and euthanasia regimes have been implemented.

3 www.bmj.com/content/bmj/320/7233/469.full.pdf

For more in-depth information see: https://www.australiancarealliance.org.au/wrongful_categories

PART 2 - in the next edition will feature more categories to consider

CATEGORIES OF WRONGFUL DEATHS BY ASSISTED SUICIDE AND EUTHANASIA PART 2 OF 2

BY: RICHARD EGAN

Our last edition of ALM 2019 outlined **categories of wrongful deaths** in jurisdictions from around the world where assisted suicide and euthanasia have been implemented:

- **A wrongful diagnosis**
- **A wrong prognosis**
- **No access to palliative care**
- **Killed without request (or while resisting)**
- **Unaware of available treatment**
- **Denied funding for medical treatment**

This edition provides a summary of the remaining categories identified by Richard Egan.

BULLYING OR COERCION

Assisted suicide and euthanasia laws usually require that a request be voluntary and free of coercion. To be truly voluntary a request would need to be not just free of overt coercion but also free from undue influence, subtle pressures and familial or societal expectations.

A regime in which assisted suicide is made legal and in which the decision to ask for assisted suicide is positively affirmed as a wise choice in itself creates a framework in which a person with low self-esteem or who is more susceptible to the influence of others may well express a request for assisted suicide that the person would otherwise never have considered.

Elder abuse, including from adult children with "inheritance impatience" is a growing problem in Australia. This makes legalising assisting suicide unsafe for the elderly. Evidence from jurisdictions that have legalised assisted suicide or euthanasia show that coercion, including the feeling of being a burden on others, is a real problem. Some supporters of assisted suicide don't care if some people are bullied into killing themselves under an assisted suicide law.

Simply requiring a physician to tick a box stating the person requesting assisted suicide is doing so voluntarily is no guarantee that the physician has the competence or has undertaken the extensive and careful inquiries necessary to establish that the person is not subject to undue influence or subtle pressure (albeit unwittingly) from family, friends or society to request assisted suicide so as not to burden others. No jurisdiction that has legalised assisted suicide has even made any serious effort to establish a genuinely safe framework in this regard. Indeed no such framework is possible. Any law permitting assisted suicide or euthanasia will inevitably result in wrongful deaths from coercion.

LACKING CAPACITY

A recent landmark study[1] shows that the majority of persons diagnosed with a terminal illness and with less than 6 months to live lack full decision making capacity. Regimes that permit assisted suicide with no requirement for a doctor to be present when the lethal substance is ingested only require assessment of decision making capacity at the time of the request – not at the time it is ingested.

Given that, even if doctors assessing decision making capacity improved their skills beyond the present very poor level, there will still be persons who are mistakenly assessed as having decision making capacity who actually are impaired in their ability to understand, appreciate or make a reasoned decision about assisted suicide or euthanasia, there will inevitable be wrongful deaths from lack of capacity. Additionally, in those jurisdictions which allow persons requesting a lethal substance for assisted suicide to be prescribed and supplied with the lethal substance for later ingestion there is a very real possibility that some of these people will have impaired decision making capacity by the time (perhaps weeks, months or even years later) when they actually ingest it. These too will die a wrongful death.

1 pdfs.semanticscholar.org/6df3/55333ceecc41b361da6dc996d90a17b96e9c.pdf

MENTALLY ILL AT RISK

People with a mental illness are at risk of wrongful death under any law authorising assisted suicide or euthanasia. In the Netherlands and Belgium mental illness is seen as a condition for which euthanasia or assisted suicide is increasingly considered to be an appropriate response. In Oregon and Washington State where the laws provide for optional referral for psychiatric assessment the evidence shows that the gatekeeping medical practitioners very seldom refer and that this results in persons with treatable clinical depression being wrongfully assisted to commit suicide. In the Northern Territory, where euthanasia was legal from July 1996-March 1997, and compulsory screening by a psychiatrist was required, there was a failure to adequately identify depression, demoralisation or other psychiatric issues which may have been treatable in all four cases of persons killed under that regime by former doctor Philip Nitschke.

There is no model from any jurisdiction that has legalised assisted suicide and/or euthanasia for adequately ensuring that no person who is assisted to commit suicide or killed directly by euthanasia is suffering from treatable clinical depression or other forms of mental illness that may affect the capacity to form a competent, settled, determination to die by assisted suicide or euthanasia.

Compulsory referral to a psychiatrist, who may have never seen the person before, for a single brief assessment of whether the person's decision making capacity about assisted suicide or euthanasia is affected by depression or other psychiatric factors is clearly an inadequate safeguard and will not make assisted suicide "safe". This leaves the mentally ill at risk of wrongful death.

SOCIAL CONTAGION OF SUICIDE

Legalising assisted suicide for some Australians undermines the commitment to suicide prevention for all Australians. Legalising assisted suicide has been shown to lead to an increase in the overall rate of suicides of 6.3% and of the elderly (65 years and older) by 14.5%.[2] This outcome is predictable because of the well-known Werther effect of suicide contagion whenever suicide is presented in a positive light as a romantic or rational act.
In addition, the families of those who commit suicide under an assisted suicide law suffer high rates of posttraumatic stress disorder.

Proposals to promote assisted suicide for some people runs an unacceptable risk of undermining efforts to prevent suicide for all other members of the community and of increasing the trauma suffered by families, friends and communities due to the suicide of loved ones.

BETTER OFF DEAD

Legalising assisted suicide poses a direct threat to the lives of some people with disabilities who may be assessed as eligible to request it. Doctors are more likely to agree that they are "better off dead" and to miss signs of depression or coercion. Legalising assisted suicide for being a burden, incontinence and loss of ability to enjoy activities trivialises issues faced daily by persons living with disability and demeans their courage in facing the challenges of life.

RIGHT TO LIFE NSW thanks, Richard Egan, a researcher who has studied euthanasia and assisted suicide since 1987, for allowing us to summarise his comprehensive work on wrongful deaths. His full research paper can be accessed here: www.australiancarealliance.org.au/wrongful_categories

Voice your opposition to the introduction of Euthanasia Legislation in NSW: Sign the petition included in this newsletter.