Plunkett Centre for Ethics

A joint centre of Australian Catholic University,
St Vincent's Health Network Sydney and Calvary Healthcare

Answers to Supplementary Questions

1 **Question re 'ideology':** The claim that there is no 'ideology' that underpins the work of Dying with Dignity NSW is largely meaningless. In common parlance 'ideology' is often assumed to be a bad thing. To say something or someone is 'ideological' is to condemn it or them. 'Ideology' is a 'boo word': it means little more than 'boo to x'. So one way of understanding this claim is to treat it as implying that Dying with Dignity as an organization is not infected with this bad thing, an 'ideology'.

2 **Question re 'choice':** In the context of this debate, the idea of 'choice' is a corruption of a great ethical principle in healthcare, the principle of respect for patient autonomy.

a. In any discussion of the ethics of healthcare, the principle of respecting the autonomy of the patient reminds us that, in the end, the person who is responsible for the life and the health (and the means to these things) is the patient himself or herself. Of course, because illness reduces people's capacity to exercise that responsibility, patients need help and support from healthcare practitioners, family and friends. Nonetheless, decisions about whether to accept or reject medical treatment are the *responsibility* (the 'choice') of the patient.

b. Today, however, that principle means little more than what it means in a discussion of flavours of ice-cream: my choice is chocolate, yours is vanilla. Your choice is assistance to undertake suicide, mine is to forgo a life-prolonging treatment. What is common to these two scenarios is the implication that individual wishes are ethically unchallengable: it as it makes no sense to say that chocolate ice-cream is better or worse than vanilla, similarly it makes no sense to say that forgoing a life-prolonging treatment is better or worse than seeking assistance to undertake suicide.

c. This is sloppy thinking: if I choose antibiotics for the common cold, a doctor has no obligation to respect my 'choice'.

d. That said, at least some proponents of this legislation intend to stretch the notion of 'choice' so widely that it will include anything that is expressed in advance about one's treatment and care in the future. Of course, they mostly do not wish to talk about this now. Their strategy is persuade the parliament to legalize doctors acting on the choice of VAD *expressed here and now* by those deemed eligible. Only when that has been accepted by the community will they point out the 'unfairness' of not making this choice available, *in advance,* to someone suffering from dementia.[1] For this reason, the proponents in the parliament should be asked to make it clear, in the parliament itself, that they unreservedly reject this move. They should be asked to commit themselves to the necessity that that the request for VAD must be *genuinely voluntary*. Otherwise they will legalize a practice according to which doctors can (ought?) administer a lethal substance to someone who, before he or she lost decision-making capacity said that they would want this option if they were to lose decision-making capacity, but who is now, in the presence of that loss of decision-making capacity, perfectly happy with continued existence.

3 **Question re 'choice' of people who have no ready access to high quality palliative care:** In circumstances in which citizens potentially meet eligibility and other requirements of the VAD Bill 2021 but do not have access to high quality, readily available palliative care, their 'choice' might best be called a 'constrained choice' if not a 'forced choice'. It is one thing to claim that citizens who have ready access to high quality palliative care should also have the choice of VAD. It is altogether another to claim that citizens who do not have access to high quality palliative care should have the choice of VAD. In the former case, the choice may be said to be 'unconstrained'. In the latter, it is clearly constrained if not forced.

4 **Question re 'patient centred care':** The claim that providing VAD is a form of 'patient centred care' is conceptual gerrymandering. The term 'patient centred' is a current buzz word in the administration of healthcare. It means little more than does the expression 'good treatment' or 'good care'. That is to say, it is a 'hurrah' word (in contrast with a 'boo' word). More substantially, the idea that VAD is a form of patient centred care relies on the prior notion that good medical practice includes the provision, under certain circumstances, of VAD. That of course is precisely one of the controversial claims in this debate. If the Parliament legalizes VAD, it is to be expected that more and more citizens will come to think that VAD is part of good medical

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[1] 'At the moment, we are struggling to get legislation for what is a very much simpler problem, and that is the person who does have a clearly demonstrable competence, who is perfectly rational, and I don't think that we should muddy the water in any way with discussions about dementia. Ultimately, if society deems that laws for people who are rational and competent are appropriate, it may well be that society will eventually see that that is perhaps an unfair situation, that people with dementia ought to be considered. And we will work out some mechanism for dealing with that. But in my opinion that will be 20 or 30 years in the distance.' Dr Rodney Syme, ABC Radio National, Australia Talks, 26th June 2008.

practice: the law has an 'educative' effect. That, of course, won't make VAD a part of good medical practice: it will just mean that more people will come to think that it is.

5 **Question re presumed capacity:** The idea that patients are presumed to have capacity makes good sense in ordinary medicine. It derives from the idea that, in medical practice, the norm is that a person comes to a doctor because they think that there is something wrong with them that they want fixed and they hope that the doctor will be able to diagnose what's wrong and provide a means for remedying it. (In the background is the idea that there will often have developed a prior relationship between the doctor and the patient.) In this context, it makes sense to start with the presumption that the person knows something is wrong, can grasp the doctor's explanation and recommendation about how to fix it, and thus can accept or refuse any treatment offered. But providing VAD is significantly different in two ways: The patient may be a complete stranger to the doctor. And what is being sought is not healthcare but the means for ending one's life. So the *presumption* of capacity, which makes sense in ordinary healthcare, does not make sense in this context. The VAD service provider may not only be ignorant of the motivation of the patient in seeking assistance. He or she will be under no legal obligation to investigate the matter: all that the Bill requires of him or her is that it 'reasonably appears to him or her' that the patient understands the consequences of making the relevant decision. No cognitive evaluation of the patient. No specialist training required of the doctor. No requirement that the doctor have a substantial discussion with the patient about the matter. It should be obvious that this approach puts whole categories of patients at risk; those who fear they are a burden on others, those suffering from depression or demoralization or loneliness; etc.

6 **Prohibition re initiating discussion of VAD with patient**. There should be such a strict prohibition. Before VAD was legalized in Victoria, there was no reason why a doctor should not raise the matter with a patient. Indeed, raising the matter with a patient could have been, and often was, a part of a genuinely open conversation aimed at revealing the patient's state of mind and heart. The patient could hardly have thought that the doctor was suggesting this option to them because it was not legal to do so. But once VAD was legalized, it made sense to prohibit doctors from raising the matter with patients just because it would likely be understood as the doctor either recommending consideration of VAD or at the very least proposing VAD as one of the available options for consideration by the patient. This prohibition is seen by proponents of VAD as an obstacle to the widespread acceptance of VAD, and is already undertake attack. It was probably no more than one of the many so-called 'safeguards' designed to get the Bill enacted in Victoria; the foot in the door, so to speak.

7 **Question re involvement of doctor with relevant expertise.** If NSW enacts a VAD Bill, it should require the involvement of a doctor with relevant specialist knowledge and relevant expertise in the management of the disease. As Professor Chye pointed out, many of the cases of unrelieved suffering at the end of life derive from people receiving incompetent treatment and care.

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Does legalizing assisted suicide inhibit the practice of unassisted suicide ?

A Sydney doctor was reported as saying that, if VAD had been legal, his wife would not have been forced to take her own life alone and without saying goodbye to those she loved.[1]

The implication of this admittedly-tragic personal story that the availability of assisted suicide will lead to a reduction in the numbers of unassisted suicide. [2]

The well- known legal scholar Richard Posner conjectured that this might be so in 1997.[3]

Indeed, his conjecture was picked up by the Swiss organization EXIT which continues to claim that 'the option of physician-assisted suicide is actually an effective form of suicide prevention'. [4]

Is this so? The question is an empirical one, capable of being supported or undermined by data. So far at least, the evidence goes against this claim.

In fact, what seems to be the case is that legalizing the practice of PAS - physician-assisted suicide (as VAD is called in most places overseas) - is associated with both ***an increased rate***

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[1] Hannah Ryan, AAP, 8 December 2021.

[2] In addition, it was asserted in parliament that 'at least 20% of suicides in people over 40 are associated with a terminal illness' (Alex Greenwich, Second Reading Speech, Voluntary Assisted Dying Bill, 2021). The percentage is more likely to be 10.7% of all suicide deaths: the 20.4% figure was reached by ignoring the total number of deaths by suicide in NSW in 2019 (943) and calculating deaths by suicide as a percentage of 495 so-called 'deaths of relevance'. In addition, the writers of the report from the National Coronial Information System, from which these figures were derived, make the point that *'[D]ata contained in this report does not necessarily infer a correlation between a terminal or debilitating physical condition and the deceased' intention to engage in self-harm, nor does it indicated that the condition was the sole or primary contributing factor to the deceased's intention to engage in self-harm.'*

[3] *Aging and Old Age* (University of Chicago Press).

[4] EXIT – Deutsche Schweiz. FAQ. http://www.exit.ch/en/faq; accessed 28 January 2022

of total suicides (assisted and unassisted) relative to jurisdictions in which PAS is not legal and with ***no decrease in rates of unassisted suicides.***

See, for example, the analysis of the change in rates of unassisted and total (unassisted and assisted) suicides in the states of Oregon, Washington, Vermont and Montana before and after the legalization of PAS by Jones and Paton. [5]

The authors acknowledge that, even with the most careful of analyses, there remain unobservable factors affecting the observed rates of suicide and that are correlated with with the legalization of PAS which may affect the drawing of conclusions.

That said, they surmise that either PAS does not inhibit (nor act as an alternative to) unassisted suicide or that it acts in this way in some individuals but is associated with an increased inclination to suicide in other individuals.

More work on this needs to be done. More work on this is being done. One thing is clear: the claim that legalizing physician assisted suicide will diminish the numbers of unassisted suicide is not supported by the available evidence.

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[5] DA Jones & Paton, D. How does legalization of physician-assisted suicide affect rates of suicide? *Southern Medical Journal,* Vol 108, No 10, October 2015.