Submission to the Australian Capital Territory's Legislative Assembly Select Committee on *the Voluntary Assisted Dying Bill 2023* by the Australian Care Alliance

The Australian Care Alliance was formed in March 2018 by health professionals, lawyers and community activists who had worked together informally to oppose the passage of the Voluntary Assisted Dying Bill 2017 through the Parliament of Victoria.

It is the considered position of the Australian Care Alliance, based on all the available evidence, that none of the jurisdictions that have legalised euthanasia and/or assisted suicide have succeeded in establishing a safe assisted suicide/euthanasia framework.

This submission addresses the question of whether the *Voluntary Assisted Dying Bill 2023* [the Bill] would enact a scheme for allowing voluntary assisted dying, that is the prescription of a lethal dose of a poison to a person for the purpose of causing the person's death either by self-administration (assistance to suicide) or administration by another person, including by a health practitioner (euthanasia) which has effective safeguards to guarantee no wrongful deaths. If the scheme to be enacted by the Bill cannot effectively prevent wrongful deaths – of the 12 categories set out in the submission - then it would be unsafe to enact it and the Bill should be withdrawn or opposed.

Scrutinising the evidence from the 26 jurisdictions which permit euthanasia and/or assistance to suicide leads to the conclusion that they are all fatally flawed[1] as they each fail to exclude the twelve categories of wrongful deaths[2], including wrongful deaths by coercion.[3] Additionally, the Bill has less safeguards than many other jurisdictions and the scheme it would enact would carry a high risk of wrongful deaths.

[1] https://www.australiancarealliance.org.au/flawed_experiments
[2] https://www.australiancarealliance.org.au/wrongful_categories
[3] https://www.australiancarealliance.org.au/bullying_or_coercion

MEDICAL ERROR AND LACK OF QUALIFICATIONS/EXPERIENCE

The *Voluntary Assisted Dying Bill 2023* (ACT) **[the Bill]** would set up a scheme in which a person who is assessed by any two "health practitioners", only one of whom can be a nurse practitioner (section 92(3)), against stated eligibility requirements. If the person is assessed as meeting those requirements, then the person's life can be intentionally ended by the administration of a lethal substance to cause the person's death.

It is quite extraordinary that the Bill would leave it to regulation to set ANY eligibility criteria for the two health practitioners who are to have the authority to assess a person as eligible to have his or her life ended. It does not even require that one of them be a doctor, let alone require that at least one of the assessing health practitioners have some relevant qualification or experience in relation to the medical condition for which a life-ending lethal substance will be prescribed.

Go Gentle founder, Andrew Denton, admitted:

There is no guarantee ever that doctors are going to be 100% right. [4]

Under the Bill the rate of medical error is likely to be high as there is no provision to ensure the two assessing health practitioners have the necessary expertise to accurately assess whether a person actually has a particular medical condition [risk of wrong diagnosis]; or whether "it is expected to cause death" (section 11 (1) (b)), the person will "continue to deteriorate" and is in "the last stages of their life" (section 11 (4)) [risk of wrong prognosis].

Additionally, neither of the two assessing practitioners may have adequate expertise in the latest treatments for the condition nor the knowledge and experience in palliative care to properly advise the person on palliative care options. [risk of missing out of effective medical treatment or effective palliative care].

1. **Wrong Diagnosis**

In a 2017 article Quassim Cassam found that "*physician overconfidence is a major factor contributing to diagnostic error in medicine*" This cannot *"be remedied by increasing physician self-knowledge"* because "*Some epistemic vices or cognitive biases, including overconfidence, are "stealthy" in the sense that they obstruct their own detection."*[5]

According to Dr Stephen Child, Chair of the New Zealand Medical Association:

"*On diagnosis, 10 to 15 per cent of autopsies show that the diagnosis was incorrect."*.[6]

[4] https://youtu.be/VvsN47Uqbt0
[5] https://www.nature.com/articles/palcomms201725#auth-Quassim-Cassam
[6] http://www.stuff.co.nz/national/politics/84252580/euthanasia-toofinal-when-the-risk-of-error-is-to-great--doctors

Deaths following legal administration of a lethal poison are fallaciously attributed to the "underlying condition" and generally no autopsies are carried out.

Italian magistrate Pietro D'Amico, whose family insisted on an autopsy, was found not to have had a terminal illness, despite being given such a diagnosis by Italian and Swiss doctors prior to assisted suicide in Switzerland.[7]

2. Wrong Prognosis

A study on the accuracy of prognoses in oncology found that "*discrimination between patients who would survive for one year and those who would not was very poor*".[8]

A study published in 2000 in the British Medical Journal found that physicians were overly pessimistic in their prognosis by a factor of 2 in 11.3% of cases.[9] **More than one in ten people given a prognosis of 12 months to live may live for 2 years or more**.

In Washington, in each year between 5% and 17% of those who die after requesting a lethal dose do so more than 25 weeks later, with one person dying nearly 3 years later.[10]

In Oregon the longest duration between initial request and ingestion recorded is 2 years and 9 months.[11]

Dr Kenneth Stevens wrote:

> *Oregon's assisted-suicide law applies to patients predicted to have less than six months to live. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live.*
>
> *At our first meeting, Jeanette told me that she did not want to be treated, and that she wanted to opt for what our law allowed – to kill herself with a lethal dose of barbiturates.*

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[7] https://www.thelocal.ch/20130711/assisted-suicide-in-question-after-botched-diagnosis

[8] https://www.sciencedirect.com/science/article/pii/S0895435696003162

[9] http://www.bmj.com/content/bmj/320/7233/469.full.pdf

[10] Washington State Department of Health, *Death with Dignity Act Reports,* 2009-2017 available at: http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData

[11] Oregon Public Health Division, *Oregon Death With Dignity Act: 2018 Data Summary, Table 1,* p.13 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

I informed her that her cancer was treatable and that her prospects were good. But she wanted "the pills."

I asked her about her family and learned that she had a son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated, and her cancer was cured.

For her, the mere presence of legal assisted suicide had steered her to suicide.[12]

Jeanette Stevens has already enjoyed 22 years of life that would have been taken from her if she had not been talked out of pursuing assisted suicide under Oregon's fatally flawed law.

3. Unable to Access Effective Treatment

Medicine is a very broad field with new treatments being developed all the time and new studies providing updated evidence on "likely outcomes" of known treatments.

Out of the four deaths under the Northern Territory's euthanasia law one would have benefited from radiotherapy or strontium but neither of these was available in the Northern Territory. Another could have been helped by stenting for obstructive jaundice or the management of bowel obstruction but Dr Nitschke, admitted to having "*limited experience, not having been involved in the care for the dying before becoming involved with"* euthanasia.[13]

A study of 45 people euthanased at Ottawa Hospital for lung cancer showed that in 13 cases there was no confirmation of the condition by biopsy - a standard diagnostic procedure. In 10 cases there was no consultation with a medical oncologist. The time between diagnosis and euthanasia being performed was as short as 3 weeks.[14]

Treatments for lung cancer have improved considerably over the last few years leading to a reduction in mortality and an increase in the five year survival rate which is now 21.7%, according to the (US) National Cancer Institute.[15]

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[12] Kenneth Stevens "Doctor helped patient with cancer choose life over assisted suicide", *Missoulian,* 27 November 2012, http://missoulian.com/news/opinion/mailbag/doctor-helped-patient-with-cancer-choose-life-over-assisted-suicide/article_63e092dc-37e5-11e2-ae61-001a4bcf887a.html

[13] http://www.healthprofessionalssayno.info/uploads/1/0/9/2/109258189/seven_deaths_in_darwin_case_studies_unde.pdf

[14] Moore S, Thabet C, Wheatley-Price P. Brief Report: Medical Assistance in Dying in Patients With Lung Cancer. JTO Clin Res Rep. 2022 Jan 21;3(2):10028, https://www.sciencedirect.com/science/article/pii/S266636432200008X

[15] https://seer.cancer.gov/statfacts/html/lungb.html

When we legalise euthanasia the result is the wrongful deaths of people who miss out on effective treatment that could have given them further years of life.

4. No access to palliative care

No case for legalising assisted suicide can properly be made on the basis that this is the only possible response to people facing unrelievable pain. Every person in the Australian Capital Territory deserves access to gold standard palliative care which can alleviate pain, including using palliative sedation as a last resort.

The Australian Pain Management Association has warned legalising euthanasia "*may lead to government having an opportunity for people to end their life with the help of another person rather than investing in early pain management support and the medical treatment and community support that people need in order to have a 'good death' and die with dignity".*[16]

Wrongful deaths occur when people are not fully informed about palliative care by specialists and request euthanasia due to misplaced fears about pain or other physical symptoms.

5. 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.

Roger Foley, who has a crippling brain disease, has been seeking support to live at home. He is currently in an Ontario hospital that is threatening to start charging him $1,800 a day. The hospital has told Roger that his other option is euthanasia under law.[17]

Of those who died from ingesting a lethal dose of medication in Oregon in 2021, more than one in twelve (8.4%) mentioned the "*financial implications of treatment"* as a consideration.[18]

Despite Medicare and public hospitals there are still cases where people cannot easily afford some effective life-saving medical treatments in the ACT. The Bill does not contain any safeguards against wrongful deaths from a Territory-funded prescribed lethal substance as an alternative to an expensive life-saving treatment.

[16] https://www.painmanagement.org.au/

[17] https://www.australiancarealliance.org.au/canada_assisted_suicide_not_assisted_living

[18] Oregon Public Health Division, *Oregon Death With Dignity Act: 2018 Data Summary, Table 1,* p.12 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

VULNERABLE PEOPLE AT PARTICULAR RISK

Demand for legalising assistance to suicide and euthanasia, under the euphemistic phrase "voluntary assisted dying", is driven by a narrow, naïve and optimistic view of "autonomy" that fails to take account of the impacts of mental illness, disability and elder abuse on vulnerable people's ability to fully exercise their self-determination. In a society that fails to value the vulnerable and reflects ingrained prejudices against those with mental illness, disability or the frailties and challenges of old age, vulnerable people can internalise these prejudices and be made to feel that others would be better off without them, and they themselves would be "better off dead".

Thew "tick-a-box" assessments of decision-making capacity and voluntariness required by the Bill simply fail to address the complexities of these social and personal situations for vulnerable people. As a consequence, the Bill poses a real threat to the lives of the mentally ill, disabled and elderly.

6. Mentally ill at risk of wrongful death

People with a mental illness are at risk of wrongful death even where mental illness itself is not seen as a condition justifying euthanasia.

Linda Ganzini reported that one in six people who died under Oregon's law had clinical depression.[19] Depression is supposed to be screened for under the law. In 2021 only two of 238 people who died under the law were referred for a psychiatric evaluation before being given a lethal substance.[20] Over the 24 years of legalisation about 289 people with clinical depression have died by prescribed lethal poison without being referred for a psychiatric evaluation.

Dr. Charles J. Bentz reported on a 76-year-old patient he referred to a cancer specialist. The patient was a keen hiker and as he underwent therapy, he became depressed partly because he was less able to engage in hiking and expressed a wish for assisted suicide to the cancer specialist, who rather than making any effort to deal with the patient's depression, proceeded to act on this request by asking Dr Bentz to be the second concurring physician.

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[19] Linda Ganzini et al., "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey", *BMJ* 2008;337:a1682, http://www.bmj.com/content/bmj/337/bmj.a1682.full.pdf

[20] Oregon Public Health Division, *Oregon Death With Dignity Act: 2021 Data Summary, Table 1,* p.12, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf

When Dr Bentz declined and proposed that the patient's depression should be addressed the cancer specialist found a more compliant doctor for a second opinion and two weeks later the patient was dead from a prescribed lethal overdose.

Dr Bentz concludes:

> *In most jurisdictions, suicidal ideation is interpreted as a cry for help. In Oregon, the only help my patient got was a lethal prescription intended to kill him."* [21]

While the Bill does exclude euthanasia or assistance to suicide solely on the basis of a mental illness or mental disorder, it lacks any safeguards to adequately identify depression or other mental illness that may be treatable and is unduly affecting a person's decision-making capacity.

7. Better off dead than disabled

Due to widespread social prejudice people with disabilities are often considered to be "*better off dead*". This puts them at additional risk of wrongful death under any scheme that legalises euthanasia.

In Oregon the **five main reasons** given for requesting assisted suicide **all relate to disability** issues: concerns about decreasing ability to participate in activities that made life enjoyable, loss of autonomy, loss of dignity, physical or emotional burden on family, friends, or caregivers and loss of control of bodily functions, such as incontinence.[22]

The late Stella Young, comedian and disability activist, wrote:

People make all sorts of assumptions about the quality of my life and my levels of independence. They're almost always wrong.

I've lost count of the number of times I've been told, "I just don't think I could live like you," or "I wouldn't have the courage in your situation," or, ***my favourite one to overhear (and I've overheard it more than once), "You'd just bloody top yourself, wouldn't you?****".*

As a disabled person who has had a lot to do with the medical profession, I can tell you that this is the space in which I've experienced some of the very worst disability prejudice and discrimination.

ABC News reported on a woman with motor neurone disease who said " I can use my left hand, my right hand is just about useless. If I can't use my left hand to wipe my bottom, then I can

[21] http://blogs.theprovince.com/2011/12/05/province-letters-icbc-egypt-assisted-suicide-oregon-christmas-pre-marital-sex/

[22] https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf

do nothing else for myself. That means someone has to do everything for me. I couldn't bear to live like that."

*The thing is a lot of people do live like that. I know many, many people who depend on personal assistants for all of their daily living tasks, some of them requiring 24-hour care**. Having to rely on someone else to wipe your bum may not be something anyone aspires to, but I'm quite sure it's never killed anyone.*** [23]

While the Bill does exclude euthanasia or assistance to suicide solely on the basis of a disability, it puts people with a disability at greater risk of wrongful death due to the ableist attitudes in society, and among health practitioners, identified by Stella Young and other disability activists.

8. Bullying and Coercion

Dr Henry Marsh, a British neurosurgeon and proponent of legalising assisted suicide has acknowledged the possibility of coercion leading to wrongful deaths under such a law but he simply doesn't care:

> *"Even if a few grannies get bullied into [suicide], isn't that the price worth paying for all the people who could die with dignity?"* [24]

A report on elder abuse in Australia[25] illustrates the environment in which legalised euthanasia would pose a real risk the vulnerable elderly.

*The estimate for the prevalence of elder abuse among community dwelling people aged 65 and older in Australia is **14.8% …** The most common form of abuse is psychological abuse (11.7%). Neglect is the next most common abuse subtype at 2.9%. For the other subtypes, prevalence rates are 2.1% for financial abuse, 1.8% for physical abuse and 1% for sexual abuse.*

Proponents of euthanasia who dismiss the risk of elder abuse are naïve, disingenuous or callously focused on demanding their "right to die" at any cost.

Adult children were most likely to commit financial, physical, and psychological abuse. Adult children were on par with intimate partners as perpetrators of neglect. Intimate partners also featured commonly as perpetrators of physical, psychological, and sexual abuse.

… [many] perpetrators were reported to have financial problems (nearly one in five).

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[23] http://www.abc.net.au/rampup/articles/2013/10/18/3872088.htm
[24] https://www.medscape.com/viewarticle/879187

[25] Qu, L. et al. *National Elder Abuse Prevalence Study: Final Report,* Dec 2021, https://aifs.gov.au/publications/national-elder-abuse-prevalence-study-final-report

*Inheritance impatience was a characteristic of 19.1% of abusers in Queensland in 2018/19***.**

Elderly people supplied with a lethal poison may be at risk from adult children and intimate partners perpetrating financial, physical and psychological abuse – including seeking to hasten the death of the person for financial benefit by bullying, nagging or persuading the person to ingest the poison or even physically forcing the person to ingest it.

There is ***a correlation between all abuse subtypes and low social support*** *(including social isolation and loneliness). A low sense of social support is the highest risk factor for physical abuse (30.4%) and the second highest risk factor for financial abuse (29.8%).*

There is also a correlation between isolation and loneliness and requests for euthanasia.

The report for Quebec for 2021/22, stated 824 (23%) of people reported "*isolation or loneliness*" as a reason for wishing to have their life ended by a lethal injection.

Where older people sought professional help, they were more likely to turn to the helping professions such as GPs and nurses … of those older people who reported taking action, ***substantial minorities considered these actions were ineffective****.* ***Responses indicating actions were ineffective were highest for financial abuse (over one third)***

There is no guarantee that medical practitioners assessing people for access to euthanasia will identify or respond to the risk of financial, psychological or physical abuse playing a role in a person's request for a lethal poison to end their life.

Without an independent witness required to be present at the time of alleged self-administration we simply cannot be sure that the lethal poison was not surreptitiously or even forcibly administered to a person. **Bald claims that there is no evidence of such abuse are of no evidential value**.

Elder lawyer, Margaret Dore, cites the case of Tami Sawyer, trustee for Thomas Middleton in Oregon. Two days after his death by assisted suicide, she sold his home and deposited the proceeds into bank accounts for her own benefit.[26]

Having financially defrauded Middleton by subtle persuasion it is possible that Sawyer also persuaded or tricked him into taking the poison. But Oregon authorities declined to investigate this possibility.

The Bill relies on the assessing health practitioners identifying coercion. The evidence, set out above, is that doctors miss evidence of coercion, leaving the abused at risk.

[26] https://choiceisanillusion.files.wordpress.com/2019/12/amicus-sawyer-arraigned.pdf noel

9. Social contagion of suicide

Legalising assistance to suicide for some people in the ACT would undermine the commitment to **suicide prevention for all** by affirming that such people would be better off dead and supporting their suicide as a rational choice to be facilitated rather than prevented.

People diagnosed with a terminal illness are at greatest risk of suicide within the first six months of diagnosis and often miss out on accurate diagnosis of depression and anxiety for which effective treatments are available.[27]

A study of US data comparing States which had legalised assisted suicide with those which have not has shown that legalising assisted suicide is associated with an increase in the overall rate of suicides of 6.5% and of the elderly (65 years and older) by 14.5%.[28]

This conclusion is supported by **evidence from Victoria**.

When arguing for the legalisation of assistance to suicide, then Minister for Health and Human Services, the Hon Jill Hennessy, claimed:
Evidence from the coroner indicated that one terminally ill Victorian was taking their life each week.[29] She argued legalisation would prevent these 50 suicides each year.

Not only has there been no such decline, but there were 62 more suicides in Victoria in 2022 than in 2017, when this claim was made. The suicide rate among those aged over 65 years increased from 2019 to 2022 by 42 per cent in Victoria, where "voluntary assisted dying" was legal—five times the increase over the same period in New South Wales where it remained illegal.

Legalising euthanasia and assistance to suicide in the ACT will not prevent suicide and is likely to lead to an increase in the suicide rate.

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[27] Nafilyan V, et al., "Risk of suicide after diagnosis of severe physical health conditions: a retrospective cohort study of 47 million people", *The Lancet Regional Health - Europe* 2023;25: 100562, Published Online 14 December 2022, https://www.thelancet.com/action/showPdf?pii=S2666-7762%2822%2900258-7 ;
Fulton JJ, et al., "Psychotherapy targeting depression and anxiety for use in palliative care: a meta-analysis*", Journal of Palliative Medicine,* Jul 2018, Vol. 21: 1024-1037*,* https://www.liebertpub.com/doi/10.1089/jpm.2017.0576 ;
Schweighoffer R. et al., "A systematic review and bayesian network meta-analysis investigating the effectiveness of psychological short-term interventions in inpatient palliative care settings.", *Int J Environ Res Public Health*, 2022;19, https://www.mdpi.com/1660-4601/19/13/7711/pdf

[28] Jones, David A and D. Paton. "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?" *Southern Medical Journal* 108 (2015): 599–604, https://nottingham-repository.worktribe.com/OutputFile/981911

[29] https://www.parliament.vic.gov.au/images/stories/daily-hansard/Assembly_2017/Assembly_Daily_Extract_Thursday_21_September_2017_from_Book_12.pdf

10. Killed without request or while resisting

In the Netherlands in 2015 there were 431 cases of euthanasia without explicit request, representing 6.06% of all euthanasia deaths.[30]

The Dutch Supreme Court has affirmed that the forcible euthanasia of a person verbally and actively resisting being killed can be legally justified based on a valid advanced directive requesting euthanasia. [31]

11. Lacking decision-making capacity

A study of decision making capacity of persons with terminal cancer and a prognosis of less than six months to live[32] found 90% impaired in regard to at least one of the four elements of decision making – Choice (15%), Understanding (44%), Appreciation (49%) and Reasoning (85%).

The study also found a significant discrepancy between physician assessments of decision-making capacity compared to the actual decision-making capacity as tested on the MacCAT-T scales. **Physicians assessed as "unimpaired" 100% of those who had impaired Choice**.

This lack of ability of physicians who are actively caring for terminally ill cancer patients to accurately assess their patients' decision-making capacity is likely to be worse in doctors who do not have an established relationship with the person before assessing a request for assisted suicide.

The Bill has no provision for any further assessment of decision-making capacity after a lethal substance has been supplied for self-administration.

The offences in sections 70 and 71 of the Bill carry only a 7 year term of imprisonment for what would otherwise be murder (life imprisonment) or aiding suicide (10 years imprisonment). With the only witness dead these offences would be difficult to prove. Providing a lethal substance to be kept at home for self-administration for an indefinite time, during which the person for who it was prescribed may very vulnerable, and may lose decision making capacity, is inherently unsafe.

NO GUARANTEE OF A RAPID, PEACEFUL DEATH

12. Inhumane Deaths by Assisted Suicide and Euthanasia

The case for legalising assistance to suicide and euthanasia **assumes** that all such deaths will be rapid and peaceful. This is not the case. An article in the journal *Anaesthesia* found:

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[30] https://opendata.cbs.nl/statline/#/CBS/en/dataset/81655ENG/table?ts=1525401083207

[31] https://www.theguardian.com/world/2020/apr/21/dutch-court-approves-euthanasia-in-cases-of-advanced-dementia

[32] Elissa Kolva et al., "Assessing the decision making capacity of terminally ill patients with cancer", American Journal of Geriatric Psychiatry, 2018 May; 26(5): 523–531, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6345171/pdf/nihms937741.pdf

Complications related to assisted dying methods were found to include difficulty in swallowing the prescribed dose (≤9%), a relatively high incidence of vomiting (≤10%), prolongation of death (by as much as seven days in ≤4%), and failure to induce coma, where patients re-awoke and even sat up (≤1.3%).

This raises a concern that some deaths may be inhumane.[33]

Many of the lethal poisons, such as sodium pentobarbital, used for capital punishment in the United States are also used for euthanasia and assisted suicide.

David Waisel, an anaesthesiologist, has testified about the use of this drug in executions.

Based on his lurching toward his arms and the lifting of his head and the mouthing of words, I can say with certainty that Mr. Blankenship was inadequately anesthetized and was conscious for approximately the first three minutes of the execution and that he suffered greatly. Mr. Blankenship should not have been conscious or exhibiting these movements, nor should his eyes have been open, after the injection of pentobarbital.

… Mr. Blankenship's execution further evidences that ***during judicial lethal injections in Georgia there is a substantial risk of serious harm such that condemned inmates are significantly likely to face extreme, torturous and needless pain and suffering***.[34]

A 2020 review, published by NPR, of 216 autopsies conducted after execution in US States by lethal injection found signs of pulmonary oedema in 84% of the cases. The findings were similar across the states and, notably, across the different drug protocols used.[35]

Anaesthetist Dr Zivot comments that "*without a general anaesthetic, many will be in great discomfort, even if outwardly they don't appear to be suffering*."

RECOMMENDATION:

As no scheme to legalise euthanasia or assistance to suicide can prevent wrongful deaths and the *Voluntary Assisted Dying Bill 2023* is particularly lacking in safeguards, the Bill should be withdrawn or opposed and the Australian Capital Territory should make no change to the law to permit the prescription, supply or administration of a lethal poison for the intentional ending of the life of any human person, either by suicide or euthanasia.

Rather the ACT should pursue more funding for and better, more equitable provision of best practice palliative care; best practice medical treatment; and social supports for

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33 https://assets.nationbuilder.com/australiancarealliance/pages/139/attachments/original/1551911256/Sinmyee_et_al-2019-Anaesthesia.pdf?1551911256

34 State of Massachussetts, County of Suffolk., *Affidavit of David B. Waisel, MD*, p. 2-3

35 https://www.npr.org/2020/09/21/793177589/gasping-for-air-autopsies-reveal-troubling-effects-of-lethal-injection

persons with disability and for the aged as well as suicide prevention for all, including those at risk of suicide following diagnosis of a terminal illness.