SUBMISSION – IMPACT OF SUICIDE IN AUSTRALIA

PREAMBLE

It would be wrong to believe that every instance of suicide is a tragic event and that governments must do everything in their power to stop individuals taking their own lives.

Rational suicide exists.

The overwhelming majority of Australians not only accept that rational suicide exists; they reserve the option for themselves if their end of life circumstances warrant. They also want to access appropriate lethal drugs to do so peacefully.

INTRODUCTION

Whilst those who drew up the reference to this committee may not have envisioned it, no study of suicide in Australia would be complete without consideration of the incidence of and impact of rational suicide by competent adults.

This submission refers only to this group.

That rational suicide exists is indisputable to all except religious fanatics. Professional polling shows that over 80% of Australians accept there are circumstances where a competent adult reasonably and rationally would, and should, be legally able to receive assistance to take their own life.

There is a cultural shift occurring regarding suicide by the terminally or hopelessly ill and the law no longer reflects prevailing attitudes toward and among this group. Most Australians acknowledge they have the right to take

their own life and believe it is a justifiable option if facing a protracted tortuous dying process.

The peak body for palliative care, Palliative Care Australia acknowledges the existence of rational suicide in its policy statement on euthanasia. Quote - *"Recognises and respects the fact that some people rationally and consistently request deliberate ending of life.*" (1)

Attachment 'A' is a Synopsis of disease and symptoms which are at best difficult, at worst impossible to control with modern palliative care. The document makes uncomfortable reading but its message needs to be heeded. That is, notwithstanding claims to the contrary, palliative care cannot relieve all suffering.

The advent of improvements in standards of living and more importantly the welcome advances in medicine, have progressively extended average life-spans. The average life-span of an Australian one hundred years ago was around 51 years. Today an Australian male is expected to live about 76 years and females 82 years. It is reasonably predicted that in future the human life-span can be extended for decades more.

Never in history have we lived so long or died so slowly.

Extended life-spans mean we now die from the ravages of degenerative diseases which often mean a lengthy period of debilitation before death. The development of ever more sophisticated drugs which enable doctors to keep a decaying body alive means death now occurs when decisions are made to 'let them die'.

30% of all Australian deaths are preceded by an action or omission explicitly intended to end a patient's life. (2) It is obvious that this percentage will continue to climb commensurate with our ability to maintain heart and lung function while the rest of the body shuts down.

The extraordinarily high support by Australian adults for legalised voluntary euthanasia clearly demonstrates widespread community acceptance of

suicide as a legitimate and justifiable course for themselves or others in limited circumstances. We no longer live in an age where "Doctor knows best." An assertive, educated population that places a high value on personal autonomy rejects the view that decisions to end life should be left to medical strangers or even family. Most people believe they should be able to make that decision for themselves.

I urge the committee to acknowledge this fact and weigh up the implications on each of your terms of reference. Not to do so would render the committee's report incomplete.

THE IMPACT OF SUICIDE ON THE AUSTRALIAN COMMUNITY

"Tragic, heartbreaking, worrying, unacceptable, unnecessary" all spring to mind when thinking about the impact of suicide on our community.

I add just one word when referring to suicide by the terminally or hopelessly ill – "shameful".

Shameful that our supposedly sophisticated society compels some to die an undignified tortuous natural death or take their own lives violently and alone. Shameful that Politicians have mostly ignored the many pleas of courageous dying citizens who have exposed their miserable lives publicly to call for compassionate law reform.

The impact of a suicide affects many people. In the case of suicide by someone already travelling the path to death the impact is probably no less traumatic for family and friends although in these cases the emotions may be mixed with relief that the suffering they have witnessed and were powerless to prevent, is over.

Law reform however could change this.

When the terminally ill have the option to openly discuss ending their suffering with a doctor, are able to access the means to a dignified peaceful

death and farewell family and friends, the experience will change dramatically.

Instead of the anguish watching a loved one endure indignity, pain and suffering then unexpectedly discovering or learning of their violent suicide, an act planned in secret leaving no opportunity for departing gestures, we would have a calm, civilised approach with the dying individual informed about their medical condition and options and in complete control of the timing of their death. With family and friends aware and able to respond appropriately the whole experience would be better for everyone.

THE PERSONAL, SOCIAL AND FINANCIAL COSTS

Quantifying the personal cost of suicide by a terminally ill individual is probably impossible however we can consider the following.

A competent adult breaches no law when taking their own life however it is unlawful for anyone to assist them. This deficiency has serious consequences which cause misery and anguish in our society today.

Some of the ramifications are;

Terminally ill adults determined to take their own life are compelled to do so in advance of when they would prefer because they have to act while they have the physical capacity to do so. This may lead to months of life being lost in fear of leaving it 'too late'.

If assistance were available, there would doubtless be cases where an individual died of natural causes because 'living remained bearable to the end.' Such cases would reduce suicide numbers.

Terminally ill Australians are travelling to Switzerland to access a lawful, peaceful, dignified death. That very sick people must resort to such expensive, exhausting travel near the end of their life is disgraceful. To exercise this option they must also do so whilst they are physically capable of

extended international travel. This raises the question of whether they would live longer if they could access the same service without leaving their own home. No doubt the answer is 'yes'.

Examples are common of terminally ill individuals scheming to be alone to suicide without interference. Fear of loved ones being implicated in unlawful acts also leads to planning to suicide secretly without consultation or goodbyes.

The committee might give thought to how a spouse of many decades would feel after discovering the body of their long suffering partner hanging in the lounge, or worse, having used a shotgun to suicide. It is true that any discovery of unexpected suicide would be traumatic – but these cases are different. I refer to rational suicide by a competent, dying adult where the law should permit a discussion of options, a dignified inducement of death at a time of choice and in the presence of loved ones - as occurs elsewhere in the world today.

ABS statistics show that Australians 75 and older suicide at the rate of 3 a week. Most hang themselves, the next most common method used is firearms, then comes gas, poison, drowning, jumping from buildings etc.

Less violent yet equally traumatic methods to suicide like refusing food and fluid have long been used. It appears that the law in Australia allows a person opting to die this way to be lawfully assisted by being kept in a coma until death. A recent court decision in Western Australia has confirmed that a competent adult can choose to suicide by refusing nourishment. This case hi-lights just how obnoxious the current law is. A doctor can lawfully assist a patient endure the process of dying slowly over 2 weeks yet they cannot lawfully assist them die in minutes by prescribing appropriate drugs.

Terminal sedation, as it is called is common practice in Palliative Care institutions. To my knowledge no statistics are kept and most institutions will claim it occurs rarely.

However one looks at it, terminal sedation is *slow euthanasia*, usually without patient consent.

Understandably some in our society are defiant of the law and will assist a loved one suicide as an act of compassion notwithstanding any punitive sanctions.

I know of instances where family members have responded to the pleas of a suffering terminally ill relative and killed them to end the misery.

The personal burden such people carry can only be imagined. Ordinary individuals, unskilled in medicine, motivated through love and compassion to end unbearable suffering and having to keep the secret for life.

Under the law a terminally ill adult cannot engage in frank discussion with a doctor about their intention to suicide. Fear of being seen to have 'aided or abetted' a suicide means the doctor can only try to talk the person out of their proposed course or refer them to a councillor to do the same. Any wonder then there is a thriving business in books and forums teaching self help suicide methods.

These are just some of the personal and social costs of making it unlawful to assist someone undertake a lawful act in circumstances where the decision to suicide is rational and understandable, made with full knowledge and due consideration.

Although the financial implications should never be a reason to decriminalise assisted suicide for the terminally ill, the facts should at least be acknowledged.

Projections of the health costs of servicing our aging population in coming decades are alarming. Part of those costs are keeping dying people alive against their free will. It is incongruous that we consume scarce medical resources to extend the duration of an unwanted tortuous existence.

THE ACCURACY OF REPORTING

The inaccuracy of suicide statistics is well documented including footnotes in ABS publications.

It would be reasonable to conclude that a number of the unquantifiable road accidents thought to be suicide would be persons who were, or thought they were, terminally ill.

In the absence of a law permitting terminally ill adults to gain access to medical assistance to die, there has been a search for new methods to induce a tranquil death. The use of inert gas is proving to be successful and is believed to leave no detectable trace in the body.

Instances of suicide by someone with advanced terminal illness using inert gas, where the necessary equipment is removed by others, are not appearing in suicide statistics. Death in such cases is inaccurately reported as being caused by the persons underlying disease.

Determining the numbers of these suicides may be impossible. These defiant acts will increase as long as citizens are denied the option of medical assistance to die, as will the pursuit of new ways to suicide peacefully that parliaments cannot thwart.

The ABS has progressively reduced the details on suicide available to the public over the past 15 years. This surprising restriction is contrary to what statistics are collected for. If Government is concerned to foster debate and search for solutions to reduce suicide one would expect more detail on the subject to be released, not less.

CONSEQUENCES OF UNDER REPORTING SUICIDE

The collection of statistics is aimed at building a factual knowledge base to enable the public, policy makers and politicians to build a better society. I

believe that the difficulty of identifying suicides that leads to inaccurate statistics is the lesser part of the problem.

In my view the voluntary restrictions on media reporting of suicide has led to a misconception about how serious suicide and the consequence of suicide is in our community. I agree there should be a code of reporting suicide directed at preventing the glorification of suicide in any way to minimise so called copycat acts by unstable individuals. I believe the current practice has gone too far the other way resulting in potentially useful community debate being stifled.

ENHANCING PUBLIC DISCUSSION

This submission focuses on rational suicide by competent adults. It needs to be recognised that with a rapidly aging population experiencing drawn out undignified, debilitating dying, the numbers of such suicides can be expected to increase. The tragedy is not that these people take their own lives; it is how they are compelled to do it in the absence of compassionate legislation permitting medical advice and assistance.

A logical starting point to enhance public discussion of suicide would be to revisit current policies that restrict how suicide is reported in the media.

With over eighty percent of the adult population supporting voluntary euthanasia it is not surprising the subject is openly discussed in coffee shops and around backyard BBQ's. The group who should be discussing rational suicide but are not, are politicians. My observation is that with rare exception, politicians avoid the issue whenever they can. Anxious to avoid antagonising a religious minority in their electorate the easy thing to do is nothing. They try to ignore the subject in the hope it will go away.

The community is not asking politicians to lead on this issue, they are asking them to catch up.

Apart from religious fundamentalists, politicians are the only group that cannot seem to grasp the shift in community attitudes brought on by a rejection of pointless protracted suffering when death is inevitable.

Hopefully this Senate inquiry will trigger a change in attitude by politicians.

GENERAL

Although not commonly understood, the major reason the terminally ill choose suicide is not pain but loss of autonomy. Official annual reports on the operation of the Oregon *Death with Dignity Act* show those using the Act to die are generally highly educated, elderly, had experienced hospice care and had health insurance. The most frequently mentioned end of life concerns are loss of autonomy, (96%) decreased ability to participate in activities that made life enjoyable and loss of dignity. Less than half mentioned inadequate pain control.

The category of people I argue believe suicide is a rational option for themselves if life becomes unbearable, do not fall into the so called 'vulnerable' or 'risk' groups such as; unemployed, (they may be but it is not a problem) high stress occupation, alcoholic, lower social status, poorly educated, history of domestic violence, sexually abused, history of self harm, previous suicide attempts. The terminally ill may however be depressed, single, physically disabled and in physical or existential pain.

Give the terminally ill sufferer the means to die peacefully, in company of loved ones, and you will witness a great diminution of depression.

I urge the committee not to dismiss my submission on the spurious grounds that with the availability of good palliative care no one should or would opt to take their own lives. Even the peak Palliative care body in Australia does not believe that.

Terminally ill individuals who have access to good palliative care yet still choose to suicide either here in Australia or go to the expense and discomfort to travel to Switzerland to receive assistance to die, are clear demonstration that the claim is false. The experience of those jurisdictions where a legal right to die exists such as Oregon, The Netherlands and Belgium also supports the view that a high standard of palliative care may reduce but will not eliminate a rational determination to bring forward inevitable death.

CONCLUSION

The official attitude to suicide seems to be that it must stem from some mental disorder and that every case is a tragic waste of life. I contend that this attitude is wrong. It fails to reflect the fact that for a very few in our society death is a liberator from a life that has become unbearable.

Current policy on suicide inhibits not only public discussion but intimate discussion between a doctor and patient. As a result the terminally ill who decide they will advance inevitable death keep their thoughts and intention to themselves. Without information or access to appropriate drugs they invariably suicide violently and alone, aggravating the trauma experienced by loved ones.

Contrast that with the situation in jurisdictions where a right to die is legal and the terminally ill can engage in consultation with their physician, obtain second medical opinions, consider palliative options and involve family and friends in farewell plans.

The message Australian law sends to the terminally ill is *"There is no law against suicide, you can refuse food and fluid and die slowly in a week or two. You can hang, drown, gas or electrocute yourself, choose whatever method you want but society will punish anyone who assists you in any way. You are on your own."*

Australian society has moved on from this uncivilised approach. More than 8 out of 10 adults want the law changed to reflect a more compassionate position and give a competent adult facing inevitable death a right to die with dignity at a time of choice.

It is hard to imagine another issue that would come near the overwhelming level of support that voluntary euthanasia has. That our parliaments have, despite a decade of prompting, refused to positively address this issue is deplorable.

Suicide is a complex and vexing matter requiring ongoing funding, research and discussion to minimise the harm most of it does in our society. There is however a small group for whom an early death is a welcome blessing. Accommodating their needs may just lead to a more enlightened debate about suicide generally.

RECOMMENDATION

1. This committee recommends the Federal Parliament returns to the Australian Territories the powers to legislate for voluntary euthanasia that were withdrawn in 1997.
2. Recommends each Australian State Parliament establishes a law reform committee to prepare draft legislation enabling competent terminally ill adults to access medical assistance to die subject to appropriate safeguards.
3. Recommends the Government commissions comprehensive national research to quantify the incidence of :-
    a. Suicide by persons with a terminal illness.
    b. Death caused by the administration of drugs intended to relieve suffering. (Double effect)

c. Death caused by withdrawing medical life support measures.

d. Death caused by a decision not to administer life prolonging treatment.

e. The administration of life ending drugs at the patient's request.

f. The administration of life ending drugs without patient request.

g. The practice of terminal sedation.

f. And related matters.

4. Recommends the Commonwealth Criminal Code (Suicide Related Material Offences) be reviewed to remove any provisions that make it unlawful for competent adults to engage in debate and access information relating to suicide.

END

REF

1. Palliative care Australia: Position Statement on Euthanasia.

2. End of Life Decisions in Australian medical practice

Centre for Human Bioethics, Monash University

Attachment A

Synopsis of Disease and Symptoms which are at best difficult, at worst impossible to control with modern Palliative and Medical care

ATTACHMENT A

Synopsis Of Disease And Symptoms Which Are At Best Difficult, At Worst Impossible To Control With Modern Palliative and Medical Care

Even with state-of-the-art palliative care many terminally ill patients will experience substantial physical and existential suffering.
Hopelessness, futility, meaninglessness, disappointment, remorse, and a disruption of personal identity are frequently experienced. The hospice ideal, therefore, to provide a pain-free, comfortable death cannot always be realised and should not be promised. It is a myth that palliative and medical care can relieve all the suffering associated with the advance of diseases like cancer, AIDS, and motor neurone disease.

Over 90% of people with terminal illness will endure their situation, but between 5 - 10% find it intolerable and request euthanasia. A minority of those with a hopeless illness also suffer intractable symptoms and request euthanasia.

1. Difficult/Impossible to Control Pain Situations

Pain, particularly that due to infiltration by cancer of extremely sensitive nerve rich areas such as the head and neck, pelvis and spine, is commonly episodic and excruciating aggravated by movement, and may be likened to a dental drill on an unanaesthetised tooth nerve.

Pain is not always adequately controlled by palliative medicine, 5-10% of cancer pain may be of this type and in some cases can only be "palliated" by producing a prolonged unconsciousness, coma or "pharmacological oblivion". This may last for days until death occurs by dehydration and circulatory collapse or retention of bronchial secretions ("the death rattle") pneumonia and pulmonary collapse.

1.1 **Raised intracranial pressure due to inoperable brain tumour**
Severe head pain due to pressure on sensitive nerve structures by tumour expansion in a confined space, may be accompanied by loss of function, e.g. blindness, paralysis, incontinence

1.2 **Infiltrating head and neck cancers with/without ulceration**
Some tumours fungate, hideously distort the face and produce foul odours.

1.3. **Lung Cancer** infiltrating the root of the neck or chest wall and damaging sensitive nerves.

1.4. **Mesothelioma** (associated with asbestosis - incurable)
Producing severe chest pain with each breath, made far worse on coughing which may be chronic and persistent - associated difficulty breathing and feelings of suffocation.

1.5 **Recurrent bowel obstruction due to widespread abdominal cancer**
Diffuse deposits of cancer obstruct the bowel, causing pain, nausea and vomiting and abdominal distension - surgery may be advised which may be either futile or of only very short-term benefit. Vomiting and malnutrition lead to a kind of starvation until death.

1.6 **Pelvic cancer** (bowel, bladder, prostate, uterus, ovary) may infiltrate major nerve plexuses affecting the legs or genitalia and cause severe neuropathic pain (+/- paralysis of sphincters/legs). Incontinence of urine and faeces can occur.

1.7 **Severe chronic poly arthritis with joint disintegration**, which renders most movements excruciating and severely limits mobility.

1.8 **Spinal cancer with nerve root pain; vertebral collapse** +/- paraplegia. One of the worst situations possible, confined to bed with - episodic excruciating neuritic pain with simple movement.

1.9. **Inoperable bladder cancer** with very frequent and painful urination, often with bleeding, blockage to flow and incontinence (hence the old medical saying "Please God, do not take me through my bladder").

1.10 **Severe chronic spinal osteoporosis** with vertebral collapse produces severe and unremitting pain.

1.11 **Recurrent carcinoma of the vulva with ulceration** + or - invasion of bladder or urethra with loss of urine (usually acidic) across the ulcerated area.

2. Non-Pain Syndromes Causing Extreme Suffering

2.1. **Cachexia** - commonly associated with advanced cancer, involves severe loss of appetite and weight, loss of energy in extreme degree and severe psychological "pain" (distress) due to this gross debilitation and loss of independence. Malnourished bed-bound patients are prone to develop ulcerating bedsores over bony prominences.

2.2. **Loss of appetite with intractable nausea and vomiting** due to either cancer itself or drug/other therapy including chemotherapy and radiotherapy.

2.3. **Obstructing oesophageal cancer** with inability to eat or even swallow saliva. Anything swallowed is vomited back.

2.4. **Chronic progressive difficulty in breathing**. Possibly with severe cough, perhaps with blood. +/- severe pain with each breath or cough. Fear of suffocation causes enormous anxiety.

2.5. **Incontinence of bowel and bladder** due to communication of these structures with the vagina, secondary to surgery/radiotherapy for cancer of the cervix or due to confusion and immobility.

2.6. **Chronic inexorably progressive neuropathic syndromes** leading to paralysis of all limbs, loss of speech, blindness, loss of control of bowel and bladder, and perhaps inability to breathe or swallow as in multiple sclerosis, motor neurone disease. The person's body functions disintegrate, yet trapped within that shell may be a perfectly lucid mind.

2.7. **AIDS** - A potentially fatal disease, often of young persons, with an horrific dying process of cachexia, immobility, incontinence and progressive loss of mental faculties.

2.8 **Total Dependence Syndrome**. The loss of dignity due to loss of independence and control in the terminal decaying phase, particularly in hospital. This is a major reason for euthanasia request.

2.9 **Blockage of lymphatic or venous drainage** of tissue fluid causes swelling of limbs, genitalia and face. In severe cases fluid seeps through the skin which breaks down.

2.10 **Severe stroke** (such as brain stem stroke or profound dense hemiplegia) can result in permanent paralysis, inability to communicate, inability to swallow (resulting in the necessity for tube feeding), commonly followed by muscle contractures, incontinence, and bedsores, and a state of total dependence which can last for years.

2.10 **Primary or secondary cancer in the liver** with vomiting and jaundice; at times painful.

2.12 **Secondary cancer in bone** (commonly prostate in origin) with pathological fracture of a long bone at the site of the secondary cancer.

- **Pen Pictures**

3.1 Cancer in the spine with nerve root pressure and spinal collapse

Pain will be lancinating around the body, and also possibly into the legs (as in sciatica). The pain will be provoked by simple movements such as turning in bed, coughing, urinating, using bowels. Its intensity and unpredictability make routine analgesic measures inadequate. Bedsores are a common risk. Incontinence or inability to urinate is highly likely. Every physical action, washing for example, is dreaded. Such a situation can last for months until the ravages of further cancer spread occur.

3.2 Multiple sclerosis

Progressive loss of motor/sensory function in a haphazard way over many years leads to virtually total loss of movement. Initially wheel-chair life, later bed-bound. Total dependence, incontinence and if speech and sight are impaired, loss of even the ability to communicate. The intellect may remain unimpaired, the person is a prisoner in a body which cannot move or function in any real way.

End