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Committee Secretary,

Senate Standing Committee on Legal and Constitutional Affairs

Department of the Senate

PO Box 6100, Parliament House, Canberra, ACT 2600

Dear Secretary,

Re: **RIGHTS OF THE TERMINALLY ILL (EUTHANASIA LAWS REPEAL) BILL 2008**

I urge the Senate Committee to **oppose** this attempt to legalise Assisted-Suicide in Australia.

My credentials

I am a Consultant Psychiatrist with 19 years clinical experience in WA, Qld and NSW. I gained my MB BS in Western Australian 1983 and Fellowship of the Royal Australian College of Psychiatrists in 1989. I have worked in State Psychiatric Hospitals, Community Clinics, in Private Practice and currently work in a Residential Drug Rehabilitation Centre with men who suffer concurrently from addictions and mental illnesses. I work on a daily basis with patients who are suicidal, and also with patients who have been traumatized by the suicide of their loved ones. I have interviewed many people who have been suicidal, have attempted suicide, some of whom could be classified as having a “terminal illness”. I know of people with and without mental illnesses who have completed suicide and I have worked with many patients affected by the suicide of others. I have also worked with patients who did not suicide but found other ways of dealing with their circumstances and were glad that they did.

Psychology of suicide

I wish to inform the Senate Committee of the psychology of suicide, based on the psychiatric literature and my clinical experience.

The proponents of Assisted Suicide speak of the “right to die” as if this is a right to be protected. However this terminology “right to die” is misleading. There is no “right” about the fact that we will all die. It is inevitable. The phrase is used as shorthand for the concept of a “right to choose how and when one would die”. This then implies that a decision of how and when one should die could be made with the same rational decision-making skills that one would use to make a purchase or decide upon a career. Based on my many conversations with suicidal people, I dispute this assumption.

In my experience, suicidal ideas and actions occur in three types of contexts:

1. Anticipated escape from a negative situation
2. Anticipated sacrifice for others
3. Mental illness

Anticipated escape from a negative situation

In overwhelming negative situations even rational people foreclose their options rather than explore alternative solutions

- Human beings have innate needs (also called drives or thirsts) for relationship with our selves, with others and with our future.
- When satisfied, these thirsts result in self worth, purpose and hope.
- Threatened or actual loss of self worth, purpose and hope are perceived as threats to our survival and generate automatic survival responses such as **feelings** that are strongly unpleasant and impel attention to the threat, **thoughts** which are focused on identifying the worst possible outcomes and **behaviours** which aim to provide escape from or control of the threat.

- Initial responses to threat are usually energetic but if ability to improve the situation seems limited or resources are perceived to be exhausted, a self-defeatist state of mind can occur. The survival responses (unpleasant emotions and negative thoughts) can become so overwhelming that these themselves are perceived as threats to survival. Thus efforts to escape emotions such as pain, helplessness, fear, anger, grief or despair predominate over efforts to deal with the original cause of threat. In such a state of mind, even rational people display limited problem-solving capacity and may choose unsuccessful strategies to improve their situation, *even if successful strategies are available*. The most frequent themes from people in a self-defeatist state of mind are "I can't/couldn't/wouldn't want to cope" and "my loved ones can't/couldn't/wouldn't want to cope". These reflect the emotional isolation and self-focus of a survival response but do not take into account the full capacity of the person concerned or untapped external resources which could be mobilized.

- In the case of patients facing terminal illness, with fear of unrelenting pain, loss of dignity, being a burden etc, contemplation of suicide as an "escape fantasy" is a normal and rational aspect of engaging with their situation. However, choosing suicide on the basis of "I can't cope", "I couldn't cope", "my family couldn't cope" etc are not only indications of loss of self worth, purpose or hope but indications of limited problem-solving capacity

- The compassionate and professional response to the suicidal mindset is to diagnose the source of the fear, and help the person find ways to cope. In terminal physical illness this may range from grief counselling, education, pain relief, managing other physical symptoms including insomnia, treating depression, anxiety, or drug use, often mobilizing support networks and facilitating communication with significant others. When these issues have improved then the fear of not coping is alleviated and so too are the suicidal thoughts. Terminally ill patients are often then able to die in peace.

Legalising Assisted –Suicide would have the harmful result that there would be less impetus for either patient or doctors to explore the real reasons for suicidal thoughts. Patients would be killed rather than be assisted to develop their own capacity to face death with dignity and peace.

Anticipated sacrifice for others

Suicidal intent is sometimes expressed as a desire to sacrifice oneself for the good of others, however this is usually a disguised fear projected onto others. For example "I don't want to burden my family" is really a message that "I'm afraid that if I become too much of a burden, my family may reject me and I couldn't cope with that". Once honest communication is facilitated, patients are often surprised to discover more support than they had expected. People who have been let down by

others and are therefore unused to trusting do have great difficulty being vulnerable. However the process of exploring their reasons for their "escape fantasy" of suicide gives opportunities for emotional connection with themselves and others, and often results in them developing a more positive outlook on their situation.

Legalising Assisted –Suicide would have the result that in it would be less likely that the real reasons for suicidal thoughts would be explored by either patient or doctors. Patients would be killed rather than be assisted to develop their own capacity to face death with dignity and peace.

In some cases, families may wish that the patient would die, to relieve the patient's or family's suffering. Legalising Assisted –Suicide would result in failure to protect vulnerable patients.

Mental Illness

The Senate Committee has no doubt received submissions detailing mental illness and suicide. I will not elaborate the mechanisms here other than to emphasise the fact that mental illness is associated with loss of selfworth, purpose or hope and therefore suicidal thoughts, plans and actions, but can be treated and should be treated.

The World Health Organisation reported in 2002 on the very high correlation between the treatable illness Major Depression and suicide:

"depression plays a major role in suicide and is thought to be involved in approximately 65-90% of all suicides with psychiatric pathologies." (World Health Organisation (2002), *World Report on Violence and Health*. WHO, Geneva. Page 192.)

Given the high association between depression – a treatable condition – and being suicidal, it is important that depression is always considered in patients who are contemplating suicide. Depression is often missed or not treated properly, especially in elderly people and those with chronic illnesses (in whom the symptoms are more difficult to detect)

The link between inadequately treated depression and assisted suicide was noted in *the Lancet* review of the patients who died in the Northern Territory under the Euthanasia legislation.

. "Four of the seven cases had symptoms of depression, including reduced reactivity, lowered mood, hopelessness, and suicidal thoughts. Case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management. PN judged this patient as unlikely to respond to further treatment. Nonetheless, continued psychiatric care appeared warranted ...". (Kissane, D, Street, A, Nitschke, P (1998), Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia. The Lancet, Vol 352, pp1097-1102.)

Note the inference that Dr Nitschke apparently inadequately managed a patient's psychiatric care. Doctors who promote suicide are not likely to be well trained in psychiatry, because those doctors who are well trained in psychiatry have the tools for the effective management of suicidal patients. We help our patients through their distress, we don't kill our patients because of their distress.

Legalising Assisted –Suicide would have the result that many mentally ill people would be killed rather than treated. Mentally ill people may also be more vulnerable to real or inferred pressure from their family to request Assisted-Suicide. The compassionate response to a person without family support who wishes to suicide

would be education, counselling and alternative support to live, in addition to treating the mental illness.

Effect on families

Suicide has a devastating effect on families, whose grief is compounded with guilt, blame, regret, often unresolved anger towards the one who died, and frustration that the survivors weren't afforded an opportunity to help the loved one cope better with their circumstances.

The legalising of Assisted –Suicide would probably increase anguish in families.

Effect on the Medical and other Helping Professionals

The Senate Committee will have read other Submissions detailing the effects on the Medical Profession. Doctors work under many stresses and like all people may be tempted to take an easy, cheaper option especially if pressured by patients and families. Doctors can foreclose on options, too. Rather than legalising Assisted – Suicide, training in palliative care and psychological treatments should be promoted.

In conclusion

For the reasons outlined above, the attempt to introduce Assisted-Suicide should be resisted on psychological, logical and compassionate grounds. The fact that doctors in Australia are not permitted to kill their patients continues to protect vulnerable ill Australians from making a fatal decision when better choices are available.

I would be pleased to speak in person to the Senate Committee should this be requested

Yours sincerely

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