

Episode 17 – Why do I have to go through Hell to get to Heaven?

[SUICIDE WARNING]

[PRAYER BELL CHIMES]

[ETHEREAL FEMALE VOICE]: There is no death. There is only me, me, me who is dying.

Bob Hawke: I think it is absurd that we should say that it is illegal that a person who is suffering terribly and is in an irremediable condition should be forced to continue to suffer. It doesn't meet any requirements of morality or good sense.

Andrew Denton: This is Australia's former Prime Minister Bob Hawke. When he says ...

Bob Hawk: It is absurd that euthanasia is not legal within this country.

Andrew Denton: ..he is speaking for the overwhelming majority of Australians.

By the end of 2016, over 100 million people on three continents will have access to assisted dying laws – an idea that first became reality in Australia back in 1995. But our law, brought in by the Northern Territory government, was controversially overturned by our Federal Government after just two years.

Since then, nearly 30 attempts to create a new one here have failed. But as the tide of history turns in favour of assisted dying, how much longer can our politicians continue to ignore the call for change?

[OPENING TITLES]

Andrew Denton: My name is Andrew Denton and you're listening to *Better Off Dead*. Since I started working on this podcast over a year ago I've spent hundreds of hours talking – and listening – to people with deeply passionate, and often divergent, views about assisted dying.

Three of the people I've spent time with – Albert, Liz and Ray – have themselves died, each differently, only one of them as they had hoped.

If there is one, unassailable, truth I've gleaned from it all, it's this: Death is complicated. People sometimes die in ways no-one could anticipate – beyond, even, the help of dedicated doctors and nurses.

In this final episode I'm going to tell you what I think a law for assisted dying in Australia should look like.

But first, let's hear from those who – other than their patients – would be most affected by that law, doctors.

First up question – who are the worst kind of patients?

[Laughter]

Cathy: The “heart sink patients” we call them in the trade.

Vic: The heart-sink patients.

Andrew Denton: Which ones?

Cathy: Heart sink. When you see them in the waiting room, your heart sinks.

[Laughter]

Andrew Denton: To discuss assisted dying and euthanasia I invited five doctors – four GPs and a specialist – to dinner. Their views on the subject ran the range.

Cathy: I am not really in favour of euthanasia although I am very in favour of as doctors assisting people to die with dignity.

Andrew Denton: This is Cathy, a long-time country GP, married to my old family doctor, Vic.

Vic: I'm cautiously against euthanasia.

Andrew Denton: That's Vic. And this is their friend, Newcastle GP Andrew.

Andrew: My position is I am cautiously in favour.

Sarah: I would say I am – it's a cautious *for* euthanasia. And we can discuss that more, I'm sure.

Andrew Denton: No, that's all we need. Thanks, Sarah!

Sarah: Later on. [Laughing]

Andrew Denton: That's Sarah, from rural Victoria. She's been a GP for almost 3 years.

Andrew Denton: Good, there's a lot of caution here tonight. I think that's good.

Cathy: We're doctors.

Andrew Denton: Yeah. [Laughing]

Paul: So I guess I'm not for or against; I'm against everything. [Laughter]

Andrew Denton: Wow!

Paul: Or question everything.

Andrew Denton: And that's Paul, physician and Professor of Medicine at Monash University in Melbourne.

Paul: I don't like the concept of euthanasia. I think it's problematic. And I am very cautious, like everyone else, about the idea of assisted dying.

Andrew Denton: I wanted to know if any of them had been asked to assist somebody to die. Here's Vic.

Vic: Yes, yes, of course.

Andrew Denton: And here's Andrew.

Andrew: Absolutely. I am aware of medical practitioners who hasten death to various degrees, and sometimes to a large degree and sometimes to a slight degree. It wasn't done on the sly, and it was done well, and the outcomes that I have seen were, I would say, quite satisfactory.

Andrew Denton: Is what Andrew is describing other people's experience?

Vic: Not as directly as that, no.

Andrew Denton: This is Vic.

Vic: More of a smaller-scale "This patient is very uncomfortable, death is likely to be in three or four days, I think she should have stronger pain relief now and not let her suffer longer," etcetera – that sort of conversation.

Andrew Denton: Andrew suspects the incidence of doctors hastening patients' deaths may be more widespread than many think.

Andrew: I think it is far, far more prevalent than we know about, basically because of the illegality of it, so it is very hard to find statistics or do surveys when you're asking people to admit to an illegal act, so you're not going to find many figures about it.

Andrew Denton: Andrew is right. What surveys do exist; however, confirm that, even without a law, Australian doctors have been assisting people to die for years. But with no law to guide them, how do they know whether or not they're doing the right thing? Here's Vic again.

Vic: I guess you have your own moral standards, and that's where you make your decisions, based upon your standards, your expectations and your compassion for the person or the family suffering, so you make your decisions on that first, and the law second.

Andrew Denton: Which is great if you have a dedicated country GP like Vic. But how can you be sure your doctor is as experienced – or as principled? Paul, who doesn't advocate a law for assisted dying, can nonetheless see the problems our current law is creating.

Paul: Where there is uncertainty in the law, where people are not certain that they would be protected, even when they are acting in accordance with accepted practice, then there are real risks that they will do things surreptitiously, and we have got no idea of the scale, we have got no idea of the detail. That's why it is important to change the law so that the people who are carrying out these acts are accountable.

Andrew Denton: Andrew agrees there is a problem.

Andrew: The fact that it's done by relatives or friends or people themselves trying to commit suicide in messy, ugly ways or physicians or GPs are doing it or surgeons are doing it, you know, without protocols or guidelines I think that's all very messy, and I think that's quite unacceptable.

Paul: It's messy and it's dangerous and...

Cathy: Yes.

Andrew: And it's dangerous and I think...

Cathy: Professionally it'd be much nicer to have some firm ground.

Andrew: We need to have something better than that.

Cathy: Not being pro-euthanasia, but having legislation that makes it clearer would certainly I think ease a lot of doctors' minds about what they can and can't do with their patients.

Andrew Denton: In spite of that, Cathy is uneasy about the thought of legalised assisted dying.

Cathy: I am sure most people around this table would not approve of capital punishment – “Ooh, we don't want governments to kill people”, and yet we are talking about giving them the legislative power to kill people.

Andrew Denton: Vic has different reservations.

Vic: At this stage it's their choice to kill themselves because they are in pain or they have terminal cancer. What if they choose to kill themselves because they are a nuisance to the family or they are holding up the inheritance or they feel like they're a waste of space because they are really depressed or whatever, and they get through all the medical systems and they are allowed to do that. The broadening of the definition really does worry me.

Andrew Denton: This is not an easy question for any doctor. And when Andrew throws up a hypothetical where he gets the incurable disease ALS it becomes even more complicated.

Andrew: If I develop that, I'd like to be able to ask somebody that I trust immensely, such as Victor, to assist me before I get to the stage where I'm choking or starving, where I've decided by some signal that I can give him that, you know, I want to finish it. And I feel as though I should be entitled to be able to make that decision without someone coming and saying, “Yes but we can do this, this and this”.

Andrew Denton: Do you think what Andrew's saying is reasonable?

Vic: Yes, yes, I do. Absolutely, and it is the dichotomy that I have to deal with in that I would be sorely tempted to help him out as a good friend – law or no law. And it would be better to have protection of the law.

Andrew Denton: Sarah, as you've been listening to this, what are you thinking?

Vic: Would you give him the green dream?

Sarah: I would find it difficult to come up with a good reason why I shouldn't help do something to help in that situation. I think one of the things I feel a little bit uncomfortable with is the power that the medical profession potentially holds in this discussion – I'll relieve your suffering, yet it's the patient who defines that suffering but it's us who decides how that suffering can be relieved and to what extent we can provide that.

Paul: It's not the job of the doctor to exercise power

Andrew Denton: This is Paul.

Paul: It's a risk and it's often an error that the doctors are guilty of, but again that's part of the appropriate ethical training of the medical profession to avoid that error.

Andrew Denton: Andrew, for you it seems to me to be very much about your rights as a patient.

Andrew: Absolutely. I'd like to have that right to make that decision and not to have someone exercise that power over me and that feels quite important to me. I may never exercise that option but I'd like to have the right to decide that. I'd like to have it for my loved ones, for my family, even for the wider community.

Andrew Denton: Surveys of Australian doctors down the years show that support for assisted dying runs at over 50%. However many of their representative bodies – the AMA, the Royal Australian College Of Physicians and Palliative Care Australia – remain steadfastly against.

But there is one national medical body that does officially support a law for assisted dying. Tellingly, they're the ones who see the suffering of patients every day and up close: They're the nurses.

Coral Levett: In our recently reviewed policy we support the change to legislation that would facilitate assisted dying.

Andrew Denton: Coral Levett is the former president of the Australian Nursing Midwifery Federation. For a decade and a half she worked in a coronary care unit where she saw hundreds of people die each year.

Coral Levett: People's bodies at end of life do amazing things. Bones break. Organs fail. Even our neural receptors, our pain receptors are hypersensitive, so we may have apparently little reason for pain but yet feel it and experience it, and often we see at end of life no amount of pain relief can relieve that, and people will ask the question. They ask you to help them end it, to finish it, to kill them. They will use all sorts of language but there is no mistake about it. People know when they've had enough. It can be very difficult for the nursing staff around them to, I guess, experience that imploring and begging to assist them to end their suffering when it happens.

Andrew Denton: Are you aware of occasions where patients have been knowingly assisted to die within the system?

Coral Levett: Yes, I think so, but very carefully. It's a very fine line and not a measurable one about how much is enough to relieve pain and how much might be enough to cease breathing. That is different for every single person, and it's not black and white. It's so grey it's hard to tell. So morphine or other opiates are administered and it would be very hard to know then whether life was shortened as a result.

Andrew Denton: Dying is complicated. Sometimes the pain relief itself can become a problem.

Coral Levett: I have seen quite a number of people who did not respond to opiates or morphine. Indeed morphine and opiates can make some people worse. It can increase their suffering. Although that is not a lot of people, that is an awful thing to see when you think you are giving somebody pain relief and you make them worse.

Andrew Denton: For nurses like Coral, faced daily with suffering, the expression "death with dignity" carries a visceral meaning.

Coral Levett: Many of the deaths I've seen are extremely undignified. I can assure you starving to death or dying of dehydration is not dignified. It's just not. And the levels of pain – people can scream for the last hours of their death in agony despite very high doses of opiates, morphine and other forms of relief. It's less than dignified I think when you're in a public place surrounded by people that you may not know very well, when other people can hear you, hear your trauma, hear your suffering, and you're generally in a strange environment. To me that's not dignified.

Andrew Denton: That some patients do die screaming in pain is a confronting thought. For some, it is also problematic. Here is Dr Karen Hitchcock, an outspoken opponent of assisted dying, on ABC TV's *Australian Story*.

Karen Hitchcock: Physical pain towards the end of life is treatable. We have very, very powerful drugs available to us. I have never in the 13 years that I've been practising in big hospitals had a patient die screaming and in pain: never. I've never had a single patient beg me for death towards the end of their life.

Heather Bell: I mean I've never seen a house on fire but I know that it happens.

Andrew Denton: Heather Bell is a 21-year-old medical student with a fiercely different perspective to Dr Hitchcock's.

Heather Bell: She's a singular doctor in a very large community of doctors in a world full of patients. That she's never seen it I'm glad that she hasn't had that experience, but it doesn't speak to the rest of us.

Andrew Denton: Heather's view about treatable pain at the end of life was shaped by the death of her mother Allison.

Heather Bell: She was a very intelligent woman and because she was diagnosed with a neurodegenerative illness and it was terminal, she knew that it would be very slow and very undignified and that it would sort of reduce her to a bit of a shell of who she was, and she struggled very much with that.

Andrew Denton: Heather was just 11 when Allison was diagnosed. She watched as, bit by bit the disease ate her mum away, attacking her body, her memory and, finally, her emotional core.

Heather Bell: She said multiple times that she wanted to die. She asked my father. He was a medical professional. He absolutely couldn't and told her that. She asked me – I spoke to my father about it – and he said, “You can't help, Heather. You'll be on a murder charge. You'll never be a doctor”. And I knew I couldn't. She told the nurses. They called me and told me regularly that that was the state she was in. She voiced it frequently and often. And when I couldn't do it because of the criminal implications and she couldn't do it because of the emotional implications it would have on me, no-one could do it because of the euthanasia laws or lack thereof. So we were just boxed in on all sides. But it was something that no-one had any illusions about whether or not she wanted it. She was very clear.

Andrew Denton: Clear and rational?

Heather Bell: Yes. She said these things about euthanasia from about the time I was 13, so it was a long time ago.

Andrew Denton: By the time Heather was 20, Allison's condition had deteriorated to the point where she was moved to a nursing home for full-time care. Then, one day, Heather got a call – her mum had developed a fever.

Heather Bell: So I went there and my mother in the space of two weeks had become completely bedbound. She couldn't eat solid foods at all. She was struggling to speak and she was being put on a lot of painkillers. So for the next seven days I slept on the floor next to her bed. She became in steadily increasing more pain and came to the point where we needed to put in a butterfly clip for morphine, and then of course those morphine injections became more and more frequent until in the last few days I had an alarm set on my phone every 2 hours that was titled “morphine”, and I would wake up every two hours to my mother's screaming in pain. And we would rush around finding the one registered nurse in that whole building. She would have to come and bring the morphine and I would spend 15, 20 minutes trying to soothe my mother, stop her screaming, stop her crying, stop her writhing around while the morphine kicked in. And then she would sort of go slack-jawed for another 2 hours, moan a lot in her sleep. So I'm not under any delusion that she wasn't in pain during her sleep; she certainly was. And then sort of just lie there for the next 2 hours and wait for it to start again.

Andrew Denton: And this went on for how long?

Heather Bell: That was about seven days that this whole injections of morphine thing went on.

Andrew Denton: Do you think there's any way in that last week where your mother could've been helped and not had any pain?

Heather Bell: I can absolutely tell you – my father’s a doctor; I’m a medical student – we were surrounded by the absolute best doctors, the best nurses. No-one wanted her to be in pain. If there was anything that could have in this world been done to alleviate her pain even the tiniest bit more, it would have been done.

Andrew Denton: If it could’ve been accessed, do you believe that Allison would’ve wanted help to die at that point?

Heather Bell: Absolutely.

Andrew Denton: For Heather, the experience of her mother’s death has left deep scars.

Heather Bell: I was standing there watching my mother take her last breaths and groaning even as she did so, and I watched the grey creep up her fingers until her entire body went grey. And then I came back half an hour later after they’d removed the catheters and everything was bleeding and there was conjunctivitis – just layers of pus – around her eyes because her body was just so susceptible to infection and nothing could be done. She couldn’t close her eyes for the last week. They would never close even when she was sleeping. You can’t put into words the toll that it takes on someone to see anyone in that state, let alone, you know, the person who brought you into the world.

Andrew Denton: To whose benefit is someone like Allison kept alive in that situation?

Heather Bell: It’s not to anyone’s frigging benefit. No-one benefited. The nurses were horrified, and they obviously will go through it again and again. I certainly didn’t benefit. My mum didn’t benefit. I can’t think of a single person who got anything out of that except for maybe the proverbial man on the moon who got a kick out of the fact that my mother didn’t take her own life and so she’s not a sinner, I suppose. I mean is that who we’re running this little show for?

Andrew Denton: Can all pain at the end of life be dealt with by drugs? No. This was confirmed, when I spoke to the director of the Sacred Heart Palliative Care unit at St Vincent’s hospital in Sydney, Professor Richard Chye.

Richard Chye: I’m not going to say I’m going to control everybody’s physical pain – no, I’m not going to be able to do that, because there will always be some patients who will have pain that is not controlled.

Andrew Denton: Across the board, palliative care physicians I spoke to acknowledged that the most difficult symptoms to treat are what they call “existential”. Here, again, is Professor Chye.

Richard Chye: It’s distress, a patient’s distress about their condition, their illness, what it is doing to them. That, I think, is the most difficult symptom to try and get over. Because it is not a physical symptom like pain or nausea, vomiting; it is a mental anguish.

Andrew Denton: To think of this issue only in terms of physical pain is to overlook what lies at the heart of it, which is not pain, but suffering.

Often the worst of what is being endured by someone dying is a mixture of many things – loss of dignity, loss of independence, or loss of control – as well as physical pain. Suffering is the key. In the case of someone like Heather’s mum, Allison, it can last for many years and cannot be controlled by drugs, however powerful.

Many Australian doctors would know this intimately. Yet, as a profession, they have remained mostly silent on the question of assisted dying.

One thing that Belgium, the Netherlands and Oregon have in common is that their laws came from the same place – an honest acknowledgement by the medical profession that doctors were already making decisions to end patients’ lives and that maybe it was better to regulate this, so that patients were better protected from malpractice and doctors from prosecution.

In each place, the medical profession played a key role in making these laws happen. In the Netherlands, the guidelines for their euthanasia laws came from the Royal Dutch Medical Society. In Belgium, the drive for regulation came from palliative care. In Oregon, after open debate, doctors voted to take a neutral position on the issue. As Leigh Dolin, former president of the Oregon Medical Association, told me:

Leigh Dolin: What the OMA was saying is the decision about assisted suicide is not a medical decision, it is a moral decision. And this kind of moral decision is not something where doctors have the answer.

Andrew Denton: As in Oregon, many doctors here have strong moral objections to helping a patient die and I totally support their right to hold that view. But there are other doctors who see assisted dying as a profound expression of their duty of care. Their questions about how laws might work deserve to be honestly and openly discussed.

As a representative of the next generation of doctors, Heather Bell would like to see that happen. I asked her how she thought other doctors could be encouraged to join the conversation.

Heather Bell: I think if a medical student is going to risk coming out and saying it, then maybe they should hike up their pants and do it too. I think the ball has to start rolling with doctors. And nurses, and you know, OTs and everyone. They all see it, they are all there at the end of it, they all should get involved and speak up, and then just realise that it’s not meant as a finger to the medical board; it’s meant as helping the patients and helping the doctors do what they need to do and what they should do without fear of reprisal.

Andrew Denton: Former nurses president Coral Levett has her own thoughts about persuading doctors to engage.

Coral Levett: As a nurse how do I change a doctor’s mind on this? I nag them, I keep on at them. There are plenty of doctors that have a similar view to our position on this, so you start with them. They’ve got to grow their own. And maybe we give them an out. We make sure they realise that they don’t have to do this, convince them that this is a choice thing. It’s a matter for people to determine their own end-of-life situations, and if you don’t want to be part of that then simply don’t. Don’t. But let those that do want to be part of this progressive change for better Australia, let them participate.

Andrew Denton: In 2016 the Australian Medical Association is reviewing their policy on assisted dying. For guidance, they might like to look at the Canadian Medical Association who in 2013 decided to take a leadership role on the issue by conducting an open conversation with their members, and the public, on end-of-life care.

Like their compatriots in Oregon they discovered that Canadian doctors were divided in their views on assisted dying. Acknowledging this they took a leaf out of the Oregon Medical Association's book by taking a vote on whether doctors should have the right to act on this question according to their conscience.

The vote was passed in favour – with 91% voting yes.

The spur for this podcast was an invitation from Michael Williams, the director of Melbourne's Wheeler Centre, to give a speech there about assisted dying.

Now, halfway through the 17th and final episode – way more than either of us ever envisaged – I'm going to hand the interviewer's microphone over to Michael so he can quiz me about how I see a law for assisted dying working in Australia.

Michael Williams: One of your starting points was the question: "Why can't we have a law that stops good people dying bad deaths in this country?" Are you any closer now, 17 episodes and 13 months in, to having an answer to that question? Why can't we?

Andrew Denton: There is a small but powerful conservative largely but not entirely religious minority that wield sufficient power in this country, and is sufficiently able to sow seeds of doubt amongst wavering politicians to block this wherever it is proposed. I don't think it's more complicated than that.

The thing I hadn't expected to find is that the medical profession itself, their leadership have made very little effort to genuinely explore this.

And on any other medical issue, if there was extreme concern expressed from patients about "We really would like some help here," you would expect doctors to step forward, but on this, as far as I can see, the leadership of medical bodies have not stepped forward; in fact they've closed the door.

Michael Williams: How did the experience of going to other countries and seeing their laws change the way you were framing this debate and this investigation?

Andrew Denton: I found the experience particularly in Belgium and the Netherlands intellectually incredibly intense. These are countries that have been having this conversation, ah both in theoretical and practical terms for many, many years. So all those questions people throw up about the elderly and disabled people, about people being coerced, they deal with this on a daily basis and seeing the deep level of thought and care that had gone into it was very, very impressive so I came back, disappointed really at how little we know here about what happens in those countries

Michael Williams: So you've – you haven't done all this work just to come up with the diagnosis that people are dying badly. You must have a prescription. Dr Denton.

Andrew Denton: We're very lucky, I think, in Australia, in that there's over a decade of experience in Europe, there's nearly 20 years in America, of hugely well-documented systems. We can see absolutely what's happened. So we can pick what we think works, and for me, what clearly works is a combination of what happens in Oregon and what happens in Europe.

And the key thing I would take from Oregon is what's called voluntary assisted dying, whereby, should you pass the criteria which enables you to be legally assisted to die – and they're very specific criteria – then you are prescribed a medication, a drink, which only you can take should you choose to take it. That makes it the most voluntary of all possible models. There are two things at the core of these laws. One is that they're voluntary, and secondly, that you have to be a competent adult to request it.

Michael Williams: So from Oregon I would take that you have to drink it, and the only exception to that is if, like Ray in episode 12, who in the last hour of his life when he desperately wanted to take the Nembutal but couldn't swallow because of his cancer, then if that person's still competent and can request it, then the doctor could inject you. But that would be the only exception.

Michael Williams: But from your perspective, the Oregonian laws are too rigid in terms of who they're available to – is that right?

Andrew Denton: The Oregon laws are deliberately narrowly written and they apply to people who have a terminal illness with six months or less to live. Now that does deal with the majority of people these laws encompass.

But I prefer Belgium and the Netherlands, where their criteria to use these laws is “unbearable and untreatable suffering”, because as with the story of Heather Bell's mother, Allison, suffering can go on for many years. If you've got something like Motor Neurone Disease or MS – which Lawrie, who we met in episode 15 has – or if you had a stroke, you can suffer unbearably for many years. To restrict it to that six-month window excludes all those people and I think unfairly.

Michael Williams: How does your version of the laws fall back on the doctors? How do they determine this question of unbearable suffering?

Andrew Denton: Doctors are presented with these kinds of questions all the time, and they do what they're trained to do, which for a question as serious as this – a request for help to die – is a long series of consultations. They go through not just the patient's symptoms but the patient's history, their biography.

And they work with the patient to try and determine if their claim for “unbearable” matches a doctor's understanding of what unbearable may be. But remember it's not just unbearable, it's untreatable. So under the laws I'm proposing, a doctor has to go through with the patient all other reasonable treatment options, including palliative care.

Um, and if all those are exhausted, then and only then if they agree that it's unbearable and if it is indeed untreatable, then they, ah, could be legally eligible to be assisted to die. Um, It surprises me when I hear doctors in Australia seem to imply that doctors here couldn't possibly do that. We are entrusting them to life and death decisions all the time. So where do we draw the line on that? Should we be withdrawing them from our hospitals because we

can't trust them with other life and death decisions? It's a nonsense, but it's one of those debating points which sound plausible on the surface of it.

Michael Williams: Do you see the voluntary nature of this thing being an opt-in thing for doctors and an opt-out for those who don't want to be part of it?

Andrew Denton: Absolutely essential. One of the cores of this is that any doctor or nurse that doesn't wish to participate can opt out. And indeed, overseas there were some doctors and nurses that chose not to participate, but who eventually came around to thinking, "I see this is a good and safe thing to do". And there are others who did participate, and then decided, "That's too emotionally hard for me. I don't want to do it again". And that's as it should be. Voluntariness is at the core of this for everybody concerned.

Michael Williams: You've said the people who want to tear down this argument again and again point to the vulnerable in society, the way in which they will be either directly or implicitly coerced into seeing themselves as a burden and opting out if you like. Do you think there are sufficient checks and balances in your law to prevent that?

Andrew Denton: Everything I am proposing is based on models that have worked very successfully overseas. The safeguards are these. First of all, you have to apply, not just to one but two doctors, independent of each other. One of whom, under my proposal, should be a specialist in what you're presenting with. So if it's cancer, that's an oncologist. You have to convince both of them independently of each other that your suffering is unbearable and untreatable.

As I said before, you have to go through all other possible treatment options, including palliative care. If they believe that there is a psychiatric driver to this, then, by law, a psychiatrist has to be brought into the mix and they too have to agree that what you are presenting is unbearable and untreatable. And that's why when I hear this scenario – that some poor granny whose kids want the inheritance are going to encourage her to go and apply for euthanasia – it's almost impossible for Granny to get through the gates of this because feeling depressed or coerced or vulnerable – all of which, I freely acknowledge, may be valid feelings and, you know, elder abuse is a real issue in Australia – but to present to two doctors independent of each other who are looking for something that's unbearable and untreatable, as a depressed, coerced, vulnerable older citizen, you're not going to meet their criteria.

And what's the jeopardy in that for the doctors? To apply for this law, a person has to do it both in writing and orally and 15 days later they have to reapply orally again. So a case note exists from the patient explaining why they are applying. The doctors have to keep case notes, which by law they have to submit to a committee of review, a committee of their peers. It also goes to the Coroner. The committee of peers, if they have any questions about how this case was conducted by the two independent doctors, who could be measured against each other, they can call either or both of those doctors into question. As can the Coroner. If there are genuine concerns about this, it can be sent to a prosecutor.

So there is great risk for a doctor in not following these laws. They can be struck off. They can be sent to jail. What, a lot of people don't think about when they say "Oh are these laws safe?" is that we're in a country right now where assisted dying is happening. We know it's happening. There are surveys down the years which support that view. Doctors said it to me

throughout the series. But we have no laws at all. We have no idea what doctors are actually doing in this country when they hasten somebody's death.

Michael Williams: There's a lot of red tape in your version of law. Does it become too hard for people to get the care that they need?

Andrew Denton: There are complaints about that overseas. You know, the peak disability group in the Netherlands who I spoke to actually said that that was the number one complaint from their members. These laws were harder to access than they wished them to be, quite the opposite of what's suggested here – that the disabled are being coerced.

There would be many – Philip Nitschke is one – who would argue that yes, this is much too hard and doctors shouldn't have this much power in the equation. But the questions raised about how safe these laws are and the need to protect the vulnerable are very genuine questions. They are the right questions. And in the end, because we're talking about literally life and death, society must take this very seriously. And I believe that the way they have dealt with this in Europe and in America, by and large, helps those people that most need to be helped. But remember one of the truths about these laws is that the number of people that use them are tiny.

You've got to be in an extreme condition to seek somebody's help to die. So it's always going to be a small number of people. And as that Oregon doctor Peter Reagan put it beautifully, he said, you know, referring to the tiny percentage of people who use this law in Oregon, which is less than half of one percent: never changed, in 17 years and he said, "I just can't imagine why anyone would think there'd be an avalanche of people wanting to use these laws".

Turns out that people just don't want to die, and I'm constantly amazed at the way other human beings are so quick to judge that people who aren't them would just give up on life. It's an incredible assumption and a deeply offensive assumption to those who are going through this level of suffering. People cling to life. Just as you or I would cling to life.

[FRAGMENTS OF 1996 NEWS STORY ABOUT NORTHERN TERRITORY EUTHANASIA LEGISLATION]

Andrew Denton: The 1995 Northern Territory law giving terminally ill people the right to ask for help to die lasted less than two years before it was controversially overturned by the Federal Government. Only four people had been able to use it.

Since then, despite overwhelming public support for such a law, none of the 27 attempts to pass a new one have succeeded. In fact, only one has got to second reading – which means it's never been seriously discussed, much less a workable law considered.

There is no other social issue on which Australian voters have been so comprehensively abandoned by their elected representatives as this. Like many, Marshall Perron, former Chief Minister of the Northern Territory and the architect of that 1995 law, thinks it's inexcusable.

Marshall Perron: We see regularly in Australia examples of people who are appealing to politicians to legislate on this subject, who are living horrific lives and face an awful demise and are begging for someone to help, and it all seems to fall on deaf ears all because the kids might put Granny down if the legislation is in place. I mean I still am a little bit staggered and

disappointed that politicians haven't really examined this issue fairly closely on behalf of their constituents and taken some action.

Andrew Denton: It is a disgust shared by one of Australia's best-known political figures.

Bob Hawke: I think it is absurd that euthanasia is not legal within this country.

Andrew Denton: This is Australia's former Prime Minister Bob Hawke.

Bob Hawk: I think it is absurd that we should say that it is illegal that a person who is suffering terribly and is in an irremediable condition should be forced to continue to suffer. It doesn't meet any requirements of morality or good sense.

Andrew Denton: The bottom line sense I get of those who suggest we can't do this in Australia is they don't trust our medical and legal system to be able to create something that is safe and workable. Does that surprise you?

Bob Hawk: Yeah, it does surprise me, and I don't think there is any ground for that apprehension.

Andrew Denton: The injection of fear into this debate is very potent. How influential is that in terms of the way politicians think about these issues?

Bob Hawk: Well politicians are by and large not the bravest of creatures. They have a pre-eminent interest in retaining the seat they hold in Parliament, whatever Parliament it is, and if they detect that there is no support and a degree of antagonism against this particular proposal, you won't detect much courage there.

Andrew Denton: When I wrote to you I said that to the best of my knowledge very few public figures of any stature in this country have come forward to say that we think these laws should exist. Does that disappoint you?

Bob Hawk: Ah yes, I think it is a bit disappointing, and I'm more than happy for my name to be associated with a clear statement of belief that the time has come when we in Australia should be getting legislation on our books which makes euthanasia not illegal.

Andrew Denton: Do you think about your end of life options?

Bob Hawk: No, I just have a sort of understanding with Blanche that something I could not stand would be to lose my marbles. And if that were in fact to happen, that something is done about it.

Andrew Denton: [Laughing] I hate to think what "something is done" means.

Bob Hawk: Well I don't expect it to be a pillow pressed exuberantly over my unwilling nose [Laughing], but I'm sure she could organise something with the family doctor.

Andrew Denton: As I write, it is March 2016. Right now, assisted dying legislation is before the South Australian parliament for the 14th time. A bill to restore rights to the Northern Territory and the ACT – including, should they choose, the right to legislate assisted dying –

is being debated in Federal Parliament. Later this year, proposed legislation will again be put before the Victorian and Tasmanian Parliaments.

The old arguments that have held such sway over our politicians – about the elderly and the vulnerable being unsafe under these laws – no longer hold.

Over a decade of experience in Europe, and nearly 20 years in America, has shown us that the safeguards do work, that good laws can be created to help the few and protect the many.

The radical idea which started in the Northern Territory in 1995 – that you could write a law to assist those in unbearable pain to die – is now embraced in The Netherlands, Belgium, Luxembourg, Columbia and much of the west coast of the USA.

In coming months, California, America's most populous state, and Canada will also embrace it when they introduce their laws for assisted dying.

Twenty years ago, four dying people in the Northern Territory were able to access a law to help them die more mercifully – before the law itself was extinguished. By the end of 2016, over 100 million people on three continents will be able to access such laws.

The trajectory of this debate is clear. The question is: Will our politicians finally engage with it?

In encouraging his fellow parliamentarians to do so, South Australian Liberal MP Duncan McFetridge urged them not to reject the assisted dying legislation now before them based on “furfies”.

Don't be a coward,” he said. “If you have problems with this legislation, take it to the committee stage [where legislation is debated in detail] ..so we can answer your questions. Have the courage to do what 80% of South Australians want – they want a choice”.

Andrew Denton: It's been intriguing, over this last year, to observe the tactics of those who oppose assisted dying. The strategy I'd heard laid out – at the anti-euthanasia convention where my journey began – by former New Hampshire legislator Nancy Elliott, was clearly evident.

Nancy Elliott: We have to be flexible. You know, when one of our arguments dies, we need to be ready to pick up another one. When you have lots of arguments, if one argument gets blown out of the water, you still have more, and each argument will reach somebody else. You only have to convince legislators that they don't want this bill. I mean you don't have to win their hearts and minds; all you have to do is get them to say, ‘Not this bill’, and then you have got your win.

Andrew Denton: Just as Nancy advised, the arguments I heard against were many and varied – suicide contagion, babies being killed by the score, palliative care degraded, trust in doctors destroyed, human lives devalued, patients killed without their consent, the elderly and disabled coerced to die.

Yet, when looked at closely, these arguments were not supported by the facts. Often, they were directly contradicted by them.

So what is the latest argument they are picking up? That it's things we can't even see or hear which make these laws bad.

Here is Dr Hitchcock raising concerns about “unspoken coercion”.

Karen Hitchcock, Q&A: There are people in our society who rely on the care of others and I think that those people are vulnerable to unspoken coercion.

Andrew Denton: And here is leading anti-euthanasia campaigner Paul Russell also warning about things that can't be backed up with evidence.

Paul Russell: I think what concerns me most is the stuff that you almost can't prove, you know – how societies change, how people's views of other people change.

Andrew Denton: Or this, from Bob McCoskrie, National Director of Family First NZ, in his submission to that country's parliamentary inquiry into assisted dying:

“Perhaps the most ominous change is one that cannot be proved. There will be an irreversible alteration to the way society and medical professionals view the demise of the elderly, the disabled ... and the terminally ill”.

Opponents are fond of saying that the burden of proof is on those who advocate these laws to show that they are safe. Yet in the face of volumes of heavily-scrutinised evidence from overseas which does exactly that, they want us to accept, instead, their counter-argument of “stuff that cannot be proved”.

Unable to explain away the overwhelming support for these laws in places where they exist, this is what their case against boils down to – an unprovable claim, a hypothetical of harm, a drumbeat of fear, anything to convince a politician “not this bill”.

Andrew Denton: If you've been listening to this podcast since the start – and, boy, do I respect your commitment – you might remember Liz, from way back in episode 2.

Liz Le Noble: Yeah. I'm starting to get fearful. So far, Andrew, I'm not fearful of death, still. I don't want to die, obviously. I am fearful of that end road to death when you are actively dying, I'm fearful of that. I know they can't control my pain. I know I have been there enough; I have been in hospital enough.

Andrew Denton: The Nembutal Liz bought and tested sat unused in her home when she died earlier this year, sedated and in palliative care. In the end, for reasons only she could know, Liz chose not to use it. But the relief of knowing it was there meant a great deal to her.

The point of changing these laws is not about forcing an outcome on anyone. It's about giving them a choice – a level of control – when illness and suffering is robbing them of other choices and control. It's about the comfort of having options.

And it's about respecting other people's choices too. Those who disagree are free to live, and die, as they choose. Doctors and nurses who feel the same way have every right not to participate.

A law for assisted dying is not about a right to die – as one Dutch doctor put it to me “death is not a right; death is a fact at the end of life” – but, instead, a right to ask for help should the suffering become unbearable and untreatable.

A basic human right not to be subjected to torture. Not an act of abandonment or murder. Rather, an act of compassion and love for those most desperately in need.

I didn't know it at the time but this podcast began almost 20 years ago when I watched my own father die slowly and painfully.

One of the things Dad always used to tell my sisters and I when we were growing up was that “There is nothing more powerful than an idea whose time has come”.

The time for this idea in Australia has well and truly come. If you think the same, don't keep it to yourself – and don't leave it to others. Tell your doctor. Tell your local member, state and federal, and encourage others to do the same.

Change happens when we make it happen. If you want to make a difference on this, you need to make a noise.

[SONG ‘FORTY EIGHT ANGELS’ BY PAUL KELLY]

[CLOSING CREDITS]