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15 March 2013

Voluntary Assisted Dying Consultation Paper
GPO Box 123
Hobart TAS 7001

By email: premier@dpac.tas.gov.au

Dear Lara Giddings MP and Nick McKim MP,
Re: Consultation into Voluntary Assisted Dying Law Reform

Community Legal Centres Tasmania (CLC Tas) appreciates the opportunity to respond to the consultation into voluntary assisted dying law reform.

CLC Tas is the peak body representing the interests of eight community legal centres (CLCs) located throughout Tasmania. We are a member based, independent, not-for-profit and incorporated organisation that advocates for law reform on a range of public interest matters aimed at improving access to justice, reducing discrimination and protecting and promoting human rights.

After careful consideration of both the law in Tasmania and analysis from jurisdictions in which voluntary assisted dying is regulated, CLC Tas strongly believes that law reform is needed. Our review demonstrates that Tasmania's laws are confusing, meaning that the boundary between lawful acts and acts warranting prosecution is often blurred. It is also of great concern that doctors, friends and family are unable to seek assistance, advice or guidance in circumstances in which a patient wishes to end their life. A lack of professional supervision means that any assistance offered has to be surreptitious with the concomitant threats of professional sanction, prosecution and imprisonment.

Of most concern however is the recognition that voluntary assisted dying is already taking place but without appropriate regulation and public and professional scrutiny.

We call on this government to act with compassion and provide patients with the reassurance that they may end their life at a time of their choosing.

The Confusion Surrounding Tasmania's Laws

Chapter XVII of Tasmania's *Criminal Code Act 1924* (Tas) sets out those acts amounting to homicide. With regard to Tasmania's voluntary assisted dying laws:

- section 154(d) of the Act states that all forms of homicide are illegal including when the death of someone suffering from a terminal illness is hastened; and
- section 163 of the Act states that it is illegal to aid another person to kill themselves; and
- section 53(a) of the Act states that it is illegal to consent to be killed.

Imprisonment of up to 21 years may be imposed for conviction of any of the sections listed above.[1]

Despite these express provisions, it has long been accepted medical practice that a doctor is permitted to provide palliative care to ease a patient's suffering even where it has the double effect of hastening their death. For example the Australian Medical Association's (AMA) position statement on end-of-life care notes that "... if a medical practitioner acts in accordance with good medical practice, the following forms of management at the end of life do not constitute euthanasia or physician assisted suicide: ... the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death".[2] This was observed during the course of a 2009 Tasmanian review of voluntary assisted dying:[3]

> Ms O'CONNOR - Dr McGushin, at one point in your testimony we you (sic) were talking about how medical practitioners administer palliation to the terminally ill and ... there are situations where out of compassion and only out of compassion medical practitioners may increase the dosage of a palliative drug, knowing that relief will be provided but also that death will be hastened. Do you accept that that does happen?
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> Dr McGUSHIN - Yes, I accept that that happens and I do it all the time and so do other doctors. But that is not what we are actually talking about because the primary intention is not to end that person's life, it is to relieve their symptoms.
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> Ms O'CONNOR - But in administering the elevated level of that drug you are doing so in the full knowledge that it is likely to hasten the sufferer's death.

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[1] Section 389 of the *Criminal Code Act 1924* (Tas).

[2] Australian Medical Association, The Role of the Medical Practitioner in End of Life Care (2007). As found at http://ama.com.au/node/2803 (accessed 3 March 2012).

[3] Joint Select Committee on Community Development, 'Inquiry into the Dying with Dignity Bill 2009', transcript of evidence given at Henty House, Launceston, on Monday 10 August 2009 at 23.

> Dr McGUSHIN - I have no problem with that at all, it is good palliative care.

CLC Tas believes that there is considerable legal uncertainty between the provisions of the *Criminal Code Act 1924* (Tas) and the widely adopted palliative practice of increasing pain relief medication to a level at which a patient will die. We are also concerned that Tasmania's current laws appear to encourage the medical profession to deliberately not ask for the patient's permission to increase pain relief medication potentially resulting in unintended outcomes. CLC Tas believes that voluntary assisted dying reform will allow for an open discussion between doctor/patient providing certainty to the medical profession that their actions are both requested and legally sanctioned and provide reassurance to patients that they will be allowed to end their life at a time of their choosing.

CLC Tas is also concerned at the legal distinction made between a patients right to refuse treatment to end their life and the prohibition on requesting assistance to end their life. An example is the recent Western Australian case of *Brightwater Care Group (Inc) v Rossiter*[4] in which a severely disabled man was entitled to instruct his carers to remove a feeding tube from his stomach. Western Australia Chief Justice Wayne Martin upheld Rossiter's right to refuse food by upholding the principle that competent persons can consent to refuse medical treatment. Chief Justice Martin noted however that there is a legal distinction between refusing treatment even though it would inevitably lead to death and circumstances of voluntary assisted dying.[5]

CLC Tas is concerned that some patients who wish to end their life have no other choice but to refuse treatment even though this may have the effect of significantly increasing discomfort, pain and suffering before their death. In our view there should be no legal distinction between the right to refuse treatment and the right of patients to request voluntary assisted dying. Whilst it is recognized that the religious or moral convictions of some patients will mean that they choose to end their life by refusing treatment, it is submitted that on compassionate grounds voluntary assisted dying should be available to those patients who request it.

Ineffectiveness of Voluntary Assisted Dying Prohibition in Tasmania

As well as the questionable legal distinction of the above examples, there is incontrovertible evidence that, despite the threat of sanction, assistance continues to be provided by doctors, friends and family to patients to end their life. In 1997 a random postal sample of active medical practitioners in Australia found that "in 30% of all Australian deaths, a medical end-of-life decision was made with the

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[4] [2009] WASC 229 (Unreported, Martin CJ, 14 August 2009). See also the United Kingdom case of *Airedale NHS Trust v. Bland*, All Engl Law Rep. 1993 Feb 4; [1993] 1:821-96.

[5] [2009] WASC 229 at [1]-[3].

explicit intention of ending the patient's life…".[6] Whilst this figure may seem high, a review of voluntary assisted dying between jurisdictions found that "a policy of prohibition does not impact significantly on the incidence of euthanasia with rates being quite comparable between jurisdictions where active voluntary euthanasia is prohibited… and those where there has been tolerance of the practice for decades…[7] It is also clear that in some circumstances Australians are travelling to Mexico where the commonly used euthanasia drug Nembutal is widely available[8] or Switzerland where voluntary assisted dying is lawful. According to the website *Exit International* there have been six Australians who have travelled to Zurich in Switzerland for voluntary assisted dying.[9]

Finally, there have been a number of cases in Australian courts involving 'mercy killings'. In the article *A right to die? Euthanasia and the law in Australia* Lorana Bartels and Margaret Otlowksi review the Australian case law of instances of active voluntary euthanasia and assisted suicide since 2000 concluding that "[i]t is very significant that, without exception, these cases have been dealt with very leniently in the criminal justice system…".[10] Interestingly, similarly lenient sentences continue to be imposed. In the most recent case, an elderly Victorian man who tried to kill himself and his terminally ill wife after realizing he was no longer able to care for her was convicted and sentenced to an 18-month community corrections order.[11]

It is worrying that voluntary assisted dying is taking place without appropriate regulation or public or professional scrutiny. CLC Tas strongly believes that regulation will ensure that appropriate legislative safeguards are implemented including a level of decision-making scrutiny that is currently lacking.

Consultation Points

With specific regard to the Consultation Points raised in the Consultation Paper, CLC Tas firmly believes that a degree of flexibility must be enshrined. The underlying

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[6] Helga Kuhse, Peter Singer, Peter Baume, Malcolm Clark and Maurice Rickard, End-of-life decisions in Australian medical practice, (1997) 166(4) *The Medical Journal of Australia*, 191-196.

[7] Margaret Otlowski, 'The Effectiveness of Legal Control of Euthanasia: Lessons from Comparative Law' as found in Lorena Bartels and Margaret Otlowski, A right to die? Euthanasia and the law in Australia (2010) 17(4) *Journal of Law and Medicine* at 551-552.

[8] Adrian Lowe and Steve Butcher, 'No conviction for euthanasia drug', The Age, April 16 2010. As found at http://www.theage.com.au/victoria/no-conviction-for-euthanasia-drug-20100415-shm2.html (accessed 3 March 2013).

[9] Exit International, 'The Swiss Model' as found at http://www.exitinternational.net/page/Switzerland (Accessed 3 March 2013).

[10] Lorena Bartels and Margaret Otlowski, A right to die? Euthanasia and the law in Australia (2010) 17(4) *Journal of Law and Medicine* at 549.

[11] Justice Betty King finding that a suspended sentence would have been the most appropriate sanction but the state government had abolished it as a sentencing option for serious crimes in 2011. Andrea Petrie, 'Court shows mercy in attempted murder case', The Age, February 26 2013 at 3. As found at http://www.theage.com.au/victoria/court-shows-mercy-in-attempted-murder-case-20130225-2f1fk.html (accessed 3 March 2013).

objective of voluntary assisted dying legislation must be compassion for the patient. It is therefore unhelpful for a patient to have to satisfy eligibility criteria such as 'unbearable' or 'unrelievable' suffering before being able to choose to end their life. Nor is it useful to require that eligibility be linked to anticipated life expectancy. Life expectancy will always involve a degree of estimation and so long as the patient is made aware of their estimated life expectancy it should remain their choice as to when they choose to die.

It is recommended that doctors have to meet face-to-face with the patient. In our opinion, it is not sufficient for a doctor to be able to review the patient's medical records. With regards to whether doctors should be able to provide the lethal dose, it is submitted that provided the doctor has no religious or moral objection to delivering the medication the option should be available. In circumstances in which the doctor feels strongly about not providing the lethal dose they should be required to refer the patient to another doctor.

CLC Tas agrees with the Consultation Paper's recommendation that the attending doctor encourage the patient to notify their family or next-of-kin of their request for voluntary assisted dying but that the request for assistance should not be declined where the patient chooses not to contact their family or next-of-kin or they cannot be contacted.

Finally, CLC Tas strongly recommends that an independent body be established to monitor and report on the operation of voluntary assisted dying legislation. Independence from government will assist in reassuring the public that appropriate checks and balances are in place as well as allowing for greater transparency.

Concerns about Voluntary Assisted Dying Consultation Paper

It is of concern to CLC Tas that the discussion on voluntary assisted dying eligibility is restricted to the 'terminally ill'. Subject to demonstrating mental competence to make the decision, all patients with a 'debilitating' or 'progressive' illness should be able to satisfy the eligibility requirements for voluntary assisted dying. This would mean that persons with dementia and other debilitating illnesses of the brain that will progressively worsen are included as circumstances warranting access to voluntary assisted dying.

We believe that the Netherlands have implemented a model that should be adopted in Tasmania. In the Netherlands there is no requirement that patients be terminally ill, with the main eligibility criteria being that the patient's suffering has 'no prospect of improvement'.[12] Whilst eligibility does extend to patients with debilitating illnesses of the brain the research suggests that adequate safeguards are

[12] Louise Bazalgette and William Bradley: "The legal and ethical status of assisted dying in our society continues to be an unresolved public policy issue ...", The Commission on Assisted Dying Briefing Paper: Key Research Themes, (London: Demos, November 2010) at 26.

in place with a recent review finding that of the 25 notifications involving patients suffering from dementia in 2010 the doctor had in each case acted with due care.[13]

Another concern that CLC Tas would like to bring to your attention is the inconsistency in limiting eligibility for voluntary assisted dying to adults aged 18 years or older. In our opinion the Netherlands model should be adopted which allows doctors to act on the request of patient over the age of 12 provided they are 'considered capable of a reasonable understanding of his [or her] interests'. For those aged between the age of 12 and 16, both parents (or guardian/s) must also agree with the individual's decision. For those aged 16 or 17, parents (or guardian/s) must be consulted, but do not necessarily need to give their consent.[14] As well, it is our understanding that in Tasmania anyone over the age of 16 is able to refuse treatment. It would therefore be inconsistent to allow patients to refuse treatment that will hasten death but not allow them to access assistance for their death. We urge you to reconsider the inflexibility of the 18 years or older requirement.

Summary

In summary it has been clearly shown that despite the threat of imprisonment, assistance continues to be provided by doctors, friends and family to patients wanting to end their life. As a result we firmly believe that legalizing voluntary assisted dying will allow for a transparency of decision-making of both the patient and the doctor/friend/family member that is currently lacking. There will be open discussion and professional and public scrutiny of decision-making. Importantly, support will be provided to the small number of patients contemplating voluntary assisted dying providing them with information about all of their options and reassuring them that if they wish to proceed, they will be allowed to end their life at a time of their choosing.

We thank you for your time in considering this submission.

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[13] Regional Euthanasia Review Committees, 'Annual Report 2010' at 10.

[14] Louise Bazalgette and William Bradley: "The legal and ethical status of assisted dying in our society continues to be an unresolved public policy issue ...", The Commission on Assisted Dying Briefing Paper: Key Research Themes, (London: Demos, November 2010) at 59. It should also be acknowledged that adoption of the Netherlands model would be consistent with Tasmanian law with patients aged 12-15 requiring the consent of both parents or guardian or a court finding that the decision is in the best interests of the patient and patients aged 16-17 having to consult their parents or guardian but where the decision remains solely with the patient.

Please do not hesitate to contact us if you have any queries or would like to discuss our submission further.

Yours Faithfully,

Benedict Bartl
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