SUBMISSION IN RELATION TO TASMANIAN VAD BILL

1. **Introduction**: This Bill is poorly drafted and suggests an intent not to merely provide for but to encourage assisted suicide.
2. **Eligibility Criteria**:
    a. **Relevant medical condition**-cl 6-condition that is advanced, incurable and irreversible and is expected to cause death (that is if there is no reasonably available treatment which is acceptable to the person and can cure or reverse the condition and prevent the expected death) -s. 5.
    b. The amended Bill provides that except where an exemption is granted the illness is expected to cause death within 6 months or if a person is suffering from a neurodegenerative disease -within 12 months.
    c. The Commission may grant an exemption if the Commission is satisfied that the prognosis of the person's of the medical condition is such that the 6/12 months limits should not apply.
    d. There are no criteria prescribed as to how this discretion is to be exercised. This means that any decision of the Commission will be impossible to review on its merit. This is the reputed most significant amendment but it is illusory.
    e. Vic -expected to cause death in period not exceeding 6 months: WA –on balance of probabilities expected to cause death in 12 months -in both cases 12 months for neuro-generative conditions.
    f. **Decision-making capacity**-cls 10 and 12; ability to understand, remember, use and communicate (by speech, writing, gestures or other means) information in relation to the decision-**this definition is ripe for abuse**. It means that assisted suicide may be granted to a person who cannot speak or write. That means that there is no safe way for a practitioner to assess capacity. Capacity assessment is a complex task. It is not merely a medical task, legal concepts have to be understood. General practitioners for example are not skilled in assessing testamentary capacity and there are expert geriatricians and psychiatrists who specialise in assessing capacity.
    g. **Voluntariness**-cls 10 and 13; it is established if the person is not acting under duress, coercion or because of a threat or promise of reward. The concepts are legal concepts and need careful consideration **with time** for them to emerge. Medical practitioners are not skilled in making what are legal judgments. Undue influence is not a factor that negates voluntariness in this section. Yet is the most likely to be in operation. It is recognised in cl 123 which creates an offence of exercising undue influence to make a request, but not here where it is most needed.
    h. **Suffering Intolerably**-cls 10 and14; persistent suffering that is in the person's opinion intolerable because of any one or more of -the medical condition or anticipation of suffering that may arise, the treatment or the anticipation of suffering because of the treatment or the complications from the condition and/or the treatment or the anticipation of suffering because of those complications. This means that a person may access assisted suicide not because of what they may be currently experiencing but what they may (or may not) experience some time in the future.
    i. **Ineligible if only suffering from a mental illness or mental disability**-cl10(2). This means that a person who is suffering from depression and another condition may access assisted suicide, by legislation which does not require any psychiatric assessment.

3. **Authorised medical practitioners**-cls 5 & 9; a practitioner registered under the Health Practitioner National Law (Tasmania) is a registered general practitioner or holds a fellowship in s specialist medical college and has relevant experience in treating or managing the medical condition expected to cause the death of the person. This means that the practitioner **does not need to be the person's treating medical practitioner**. The practitioner need not have any psychiatric qualifications.
    a. Contrast Victoria Both the coordinating and consulting medical practitioners must be **fellows of a specialist medical college or be vocationally registered general practitioners** (cl 10). The Act also requires that either the coordinating or consulting medical practitioner must have at least five years of experience post-fellowship and that at **least one of the practitioners must have relevant expertise and experience in the person's disease, illness or medical condition** (cl 10(2)(3)).
    b. Contrast WA s 17 A medical practitioner is eligible to act as a coordinating practitioner or consulting practitioner for a patient if —(a) the medical practitioner — (i) holds specialist registration, has practised the medical profession for at least 1 year as the holder of specialist registration and meets the requirements approved by the CEO for the purposes of this subparagraph; or (ii) holds general registration, has practised the medical profession for at least 10 years as the holder of general registration and meets the requirements approved by the CEO for the purposes of this subparagraph.
    c. The new restrictions do not apply to the administering health practitioner, that is the person who administers the poison (the Bill acknowledges the potions are poisons s69(5)(d)). This is arguably the most important person. That person may be a medical practitioner or a nurse of at least 5 years experience. See [8] below.
4. **Certain persons not to initiate discussions about VAD**-cl 17; this is new. A registered health practitioner who provides health services or care services to a person must not initiate discussions about or suggest to a person that they may wish to access VAD.
    a. However a medical practitioner may do so if at the same time the practitioner also informs the person of the treatment options and palliative care options available. This medical practitioner need not be an authorised medical practitioner-see [3] above.
    b. This means that the Bill expressly recognises that a medical practitioner can suggest that a person may wish to participate in VAD.
    c. Further a health practitioner a health practitioner can initiate discussions or suggest VAD if they say before the end of the discussion that a medical practitioner would be the best person with whom VAD should be discussed.
    d. This means a Chinese health practitioner may suggest VAD to a person if before the end of the discussion they say that the best person to discuss this with is a doctor. Further the Bill does not say anything about an unregistered health practitioner like a carer.
    e. This provision is illusory in its protection.
    f. In Victoria -VOLUNTARY ASSISTED DYING ACT 2017 - SECT 8

Voluntary assisted dying must not be initiated by registered health practitioner

(1) A registered health practitioner who provides health services or professional care services to a person must not, in the course of providing those services to the person—

(a) initiate discussion with that person that is in substance about voluntary assisted dying; or

(b) in substance, suggest voluntary assisted dying to that person.

Contrast WA:
10. Health care worker not to initiate discussion about voluntary assisted dying
(1) In this section — health care worker means — (a) a registered health practitioner; or 29 (b) any other person who provides health services or professional care services. (2) A health care worker who provides health services or professional care services to a person must not, in the course of providing the services to the person — (a) initiate discussion with the person that is in substance about voluntary assisted dying; or (b) in substance, suggest voluntary assisted dying to the person. However there are exceptions as in the Bill.
But carers are covered.

5. **Communication or request by another-**cl 15; if the person cannot communicate with the medical practitioner it can be done through another. If this is a language issue the medical practitioner has no way of knowing if what is said is correct. There is no requirement for a trained interpreter.
6. **Time from first to final request**-cls 18, 30 and 53-minimum total of 96 hours from first to final request; Vic 9 days s 38; WA 9 days s 48. Tasmania will have the shortest time.
7. **Provision of Information**-cl 24 -information as to condition, treatment, complications prognosis, provision of palliative care etc. Despite the changes re an authorised medical practitioner, given the treating medical practitioner is not required to be involved nor is there any need for the involvement of a psychiatrist, the legislation still invites perfunctory advice, especially in relation to palliative care. It is practically difficult if not impossible to communicate the holistic nature of palliative care, which needs to be experienced to be understood. It is signal that **palliative care is not defined in the Bill; it is treated as an afterthought** when it should be for prime importance.
8. **AV Meetings allowed-** cl 27; a medical practitioner is allowed to see a person by way of AV link. It is not possible to properly assess issues of capacity and voluntariness or to examine a person to give a prognosis by Zoom.
9. **Final Determination of capacity and voluntariness may be made by a registered nurse**-cls78 and 62 (2). This imposes an unfair burden on registered nurses. Registered nurses are never proffered as expert witnesses as to capacity in testamentary cases, because exceedingly competent as they are their training does not adequately equip them to make these decisions. This makes this final step illusory.
10. **Final Permission may be given by a third party if person unable to sign**-cl 82. This means that a person may have their life taken on the signature of another. It they cannot write or even make their mark; this means that any assessment of capacity must be suspect.

11. **Poisons introduced into homes**-cl 71(5)(d) and 91; the poisons are to be kept in a locked receptacle. Given the breadth of the lead time to expected death (no time limit) this could be several years and there is no mechanism to check on the storage of the poisons.
12. **No protection in self administration**-cl 91-93; Where the poisons are in a home there is no protection to stop them being administered surreptitiously and without consent and no coronial investigation is required.
13. **Death not suicide**-cl 38; That creates a legal fiction which is bad legislation and bad policy. The record should accurately state the cause of death. Such provisions are may be the subject of a *Constitution* section 109 inconsistency with the duty of utmost good faith and disclosure in the *Insurance Contracts Act 1984* (ss13 and 21) and could cause directors of life insurance companies to refuse to accept certain risks given their obligations under section 48-50 of the *Life Insurance Act 1995*.

Dated 17 December 2020

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ACL Tasmanian Director.