

Submission on the End-of-Life Choices  
(Voluntary Assisted Dying) Bill 2020

Human lives matter. Our life, whatever its quality, is our greatest gift. We accept that there is no greater love than that of laying down one's life for another. Hence we honour our war dead who made what we term as "the supreme sacrifice" and we rejoice that heroes like Teddy Sheean should be appropriately recognized.

Many civilized societies including, thankfully, our own have abolished capital punishment and not only on the ground that the convicted person may have in fact been innocent. Yet we now face the prospect of legitimizing the deliberate destruction of the lives of those who, admittedly through their own apparent choice, have elected that course but have asked others to implement it.

While I respect the opinions of those who promote the current Bill and accept that they are moved by compassion for those who find their life intolerable and wish to end it, it is not right that the State should authorize certain people, no matter how well intentioned, to administer lethal doses of a VAD substance with the express purpose of ending the sufferer's life. We should aspire to minimizing that suffering by improving the quality of medical, psychological and spiritual care available to and wanted by the patient.

While self preservation is one of the most basic human instincts there are some who see it as their right to terminate or have help from another in terminating their lives at a time and in a manner of their choice and may wish to secure the exercise of that right by engaging in the voluntary assisted dying process provided by the Bill. Others however are, by reason of age, incapacity, pressure and feelings of depression and worthlessness, vulnerable to being persuaded to do so when their personal choice would never be to allow others to take active steps to ensure their death.

But quite apart from the issue of principle there are pragmatic reasons for avoiding any risk of putting to death people whose decision may have been induced by coercion or who on reflection change their minds but lose the will or the ability to express that change. I wish to make some comments on the fragility of a number of provisions which, while purporting to offer safeguards against

abuse, do not provide adequate protection to the vulnerable patients who embark on or continue the process of VAD against their better judgment.

Bob Hawke spoke in support of euthanasia on *ABC National Radio* in 2016 but he did not mince his words on safety. “We’ve got to realize”, he said “the genuine concern some people have that greedy family members may precipitate or attempt to precipitate an early departure so they can get their grubby hands on the estate. And it’s absolutely essential that the legislation be framed in a way which would virtually make that impossible or very, very, very difficult.”

The Bill proposes to make it a crime, punishable by up to five years’ imprisonment, to coerce a sick person to apply for assisted dying. From a criminal law perspective this step only addresses one aspect: the consequences of detection. It does not address the other aspect of deterrence: the chances of detection. This is an enduring problem for euthanasia safeguards. The deterrence value of prison is questionable when the risks of getting caught are likely to be very low, especially if coercion occurs behind closed doors and leaves no physical evidence.

It is doubtful that the Bill can rely on vulnerable people complaining about coercion exerted by, for example, a primary carer. That takes a degree of bravery. In reality vulnerable elderly people can feel afraid, trapped and powerless. In any case it is clear that the risk of complaints does not prevent other crimes against elderly people like theft, fraud, rape and other forms of violence – as we have seen in recent commissions investigating family violence. Of course if coercion works and the victim dies, then the central witness for any prosecution disappears.

A new feature of this Bill is that it proposes that eligible patients be permitted to take lethal doses home with them, potentially for a year. The objective of this approach may well be to give comfort to patients through their knowledge that they can end their lives at any time. However such patients will be at increased risk of crime if they have lethal doses of medication in their homes. For instance, they could be verbally persuaded into taking the lethal dose, perhaps with deliberate reduction in their quality of care. Indeed some offenders might trick the patient into swallowing the dose, or might slip the dose into the patient’s food or drink.

If these suggestions seem fanciful, note that the Victorian Commission on family violence received reports about relatives using intimidation, verbal abuse or violence to steal from the elderly. In one case the will and bank details of an elderly person were altered after she was drugged.

Recent NSW murders by carers using insulin in aged care facilities are examples of the fact that offenders are more likely to kill if they have a plan to avoid detection. This has a direct bearing on the Bill because an offender would know that if he or she tricked or coerced the patient into ingesting a lethal dose, toxicological evidence would point to voluntary self-administration. In other words authorities would assume the death was the patient's choice. Suspicions to the contrary would be very hard to prove in the absence of bruises, video footage and so forth.

To reduce risks the Bill requires a health practitioner to be present when a patient wants to take the lethal dose. However if the patient is authorized under the legislation to privately administer the dose there is no such obligation and the dose may be self-administered alone or in the presence of such company as the patient wishes and as can be accommodated. The potential for sensationalizing such activity, having regard to the current appetite for "reality" television and social media, is something requiring careful scrutiny by the Legislature.

Although the Bill requires the making and approval of more requests for access to VAD than some other unsuccessful Bills in this State and some of the enactments in Mainland States the protection this gives is somewhat illusory. The scheme of the Bill is for a patient to seek that access by making a First Request orally or in writing to an authorized medical practitioner who

- a) is of five years' standing
- b) has successfully completed an approved voluntary assisted dying training course within the preceding five years
- c) is not a member of the patient's family and
- d) has no knowledge or belief of the likelihood of receiving any financial benefit as a result of the patient's death.

That doctor must satisfy himself (for the sake of brevity I shall use the device of the masculine being taken to include the feminine) of the eligibility of the patient which includes requisite age, residency,

decision making capacity and voluntariness, and is suffering intolerably in respect of a relevant medical condition. In the process of doing so he must personally inform the patient of the matters set out in Sec 7. Where the patient does not speak the same language as the doctor, relevant communication may be made by way of translation by a person familiar with the patient's language, or other means of communication if the patient cannot speak. There is no provision made for a professionally recognized interpreter or any means postulated for ensuring that the doctor can engage in a meaningful and safe exchange with the patient. The "interpreter" may be a family member who is more interested in persuading the doctor of the patient's eligibility than the patient himself (see sec 14).

If the doctor accepts the patient's first request he becomes the patient's PMP (Sec 20) and must inform the Commissioner. He must then give the patient the extensive details set out in sec 22. Once again the problem of the efficacy of the "interpreter" arises. Having made the determination that the patient is eligible he must reduce it to writing and advise the Commissioner.

After the lapse of 48 hours (shorter if the patient is imminent danger of death etc) the patient may make a second Request, this time in writing and witnessed by two people not disqualified by sec 29. The PMP then makes a second determination in much the same way as the first and it is recorded and sent to the Commissioner.

For the first time now a second opinion is required from another "medical practitioner". This doctor is not designated as "an authorised medical practitioner" and is not therefore required to have the same qualifications as the first. He must not be a psychiatrist but may be a medical practitioner without five years' standing and without having completed the approved VAD training course. He may also be a member of the patient's family and have expectations of a financial benefit if the patient dies. Likewise there is no prohibition on his being in the same medical practice as the first doctor. The second doctor is called the CMP. There are provisions against "shopping" for a compliant 2<sup>nd</sup> opinion where others have already determined the patient is not eligible but nowhere is there any obligation to consult with the patient's current or previous general practitioner or family. The patient and both doctors may be total strangers (or in the case of the second doctor may be a member of the patient's family). In matters, as here, of life and death there is a

need for transparency and utmost good faith, yet as the Bill stands there are insufficient safeguards to protect the patient from being found eligible without proper inquiry having been made and with him being shunted off for a second opinion by the first doctor's own medical partner. Where there is no requirement that proper inquiry be made of the patient's previous medical history, and assessments of capacity to make vital decisions, voluntariness and resistance to coercion are left to be made by total strangers without any input from spouse or close family, there is danger that an industry of death doctors will grow and too readily treat the patients' requests at face value and without proper inquiry.

Then comes the Final Request from the patient. It is made to the first doctor (PMP). It is basically a re-run of previous examinations to confirm the patient's eligibility. If it is confirmed the PMP decides whether he will administer the fatal dose and become the AHP or get the Commissioner to appoint another medical practitioner or registered nurse as AHP. Thereafter arrangements are made for the prescribing, delivery and safe custody of the lethal VAD substance and administration of it. A final assessment of decision making capacity and voluntariness is made by the AHD within 48 hours before a final permission from the patient to proceed to VAD is given. This permission is to be in writing signed by the patient or if he cannot do so by a designated person (other than the doctors and persons excluded by sec 14). Once again we have the problem of communication whether by word of mouth, the use of an interpreter or the interpretation of signs understood by someone "who is familiar with (the patient) or the method of communication".

Once the final permission is given the dose can be administered by the AHP. I have already dealt with some of the problems of private self-administration.

The Bill in Part 15 deals with Reviews by the Commissioner of decisions made throughout the process. Pending the outcome of the Review there is in effect a stay of proceedings (see sec 95) but if the challenge is to one determining the existence of eligibility and the challenge is over-ruled it seems that there is nothing to stop the immediate administration of the dose if all other procedures have been found to be in order. While the Supreme Court is given jurisdiction by way of special case or appeal brought within 14 days a party aggrieved by a determination that the patient was eligible

would have to move swiftly to seek an injunction from the Court to halt administration of the dose until the Court can decide the appeal. Furthermore the appeal is too constrained. It should be a hearing de novo from the Commissioner with a power to lead fresh evidence. The Commissioner's and Deputy's functions are both administrative and quasi-judicial yet no specific qualifications are laid down for their appointments. Sections 109 and 110 merely require that the Minister considers that each has relevant qualifications or experience.

The proposed legislation is complex and it is problematical that the matters which the doctors are required to determine or explain to their patients will in fact be determined correctly and explained adequately. The cost of establishing, staffing and running the administrative machinery to ensure that the objects of the Bill are likely to be high and would, in my respectful submission, be better spent on improving the quality of existing care.

The Honourable William Cox AC, RFD, ED, QC.  
Former Chief Justice of Tasmania and  
Former Governor of Tasmania.