The University of Tasmania's Independent Review of the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020

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Thank you for this opportunity to submit our views on the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 which was tabled in the Legislative Council by the Honourable Michael Gaffney MLC on 27th August 2020, and tabled in the House of Assembly in November 2020. We oppose legalising euthanasia and believe that intentionally ending a human life is wrong and unnecessary. We also have good reasons to be concerned about the general suicide rate in Tasmania and the serious risk this Bill poses to its worsening outcomes as it has done elsewhere. We have been involved in suicide-prevention and end-of-life pastoral care within Tasmania for several decades now and thank the review panel for this opportunity to express our concerns about this Bill.

1. Our Common Concern

While we oppose this Bill, we do not wish to be misunderstood as suggesting that a person at the end of their life should have their life artificially and unnecessarily prolonged at all costs. Neither do we wish to suggest that any person should have to endure intolerable and untreatable pain at the end of their life. It seems to us that the proponents of this Bill may be similarly motivated and if this is the case it means that we share *a common concern* for those at the end of the life.

However, unlike the proponents of this Bill, we are satisfied that this concern can be achieved ethically through genuine palliative care. We were deeply concerned by the way palliative care was misrepresented in many of the Legislative Council speeches to this Bill during its Second Reading.

2. The Use of Euphemisms

A euphemism is a *good word substituted for something harsh, unpleasant, or embarrassing*. This Bill employs several euphemisms and seeks to outlaw the use of what it considers to be *dysphemisms* which describe *precisely* the same event or outcome. An example of this is found in Part 20, Section 138.

> For the purposes of the law of this State, a person who dies as the result of the administration to the person, in accordance with this Act, of a VAD substance or a

> substance under section 88, or the self-administration by the person, in accordance with this Act, of a VAD substance, does not die by suicide.

Even the Bill's title is euphemistic. *End-of-Life Choices* sounds as if the Bill is presenting choices or options, but it does neither. In the Legislative Council Second Reading speeches this 'choice' was presented by its proponents as: take the VAD option at a time and place of your choosing with dignity and without pain; or, take the risk of dying a natural death in an undignified manner while suffering intolerable pain. This is a false dichotomy of end-of-life *choice*. It sounded like, "If you do not agree with physician-assisted-suicide, you don't have to choose it!" But the moral logic of this mischaracterisation is precisely the same as saying, "If you do not agree with slavery, you don't have to choose to own one!"

Even the subtitle of the Bill, *Voluntary Assisted Dying* is referred to precisely in most other jurisdictions as *Physician Assisted Suicide* (PAS). The term *voluntary* makes the Bill sound *empowering*, when the truth is that it will inevitably *disempower* many of our most vulnerable in our State, especially those already prone to suicide-ideation—the mentally ill, and the demoralised.

3. Eligibility, Subjectivity, and Fear

There are good reasons to be deeply concerned about the message that this Bill sends to those who are suffering psychologically. While the general public assume that this Bill exclusively addressing those with a terminal illness with a prognosis of just months to live, there are provisions within the Bill that are not tied to a purely *physical* diagnosis. Example, Part 2, Section 7

> (g) the reasonably available treatment that may relieve the mental or physical suffering of the person that is related to (or that occurs in anticipation of the suffering, or in expectation, based on medical advice, of the suffering, that might arise from)

This provision also accommodates not *what is*, but what *might be* (but not necessarily *will be*). That is, a person may have a diagnosis of a terminal physical condition, or be in mental anguish, yet not be presently suffering, and still be eligible for VAD based on the *anticipation* of untreatable physical suffering in the future. The remedy for such fear is not PAS but *reassurance* from medical and allied health professionals (such as hospital/hospice

chaplains), that they will be appropriately cared for and treated. Thus, even though the Bill seems to empower the *voluntary* notion of decision-making by the patient wishing to have their life ended by their registered PMP, it is not only *their* subjective decision called for, it also of necessity calls for the subjective evaluation of their subjective decision-making capacity by their PMP (Part 3, Section 12) -

> (3) In determining whether or not a person has decision-making capacity in relation to a decision, regard must be had to each of the following:
>
> (a) a person may have the capacity to make some decisions and not others;
>
> (b) a person's lack of capacity to make a decision may be temporary and not permanent;

- which makes the whole process even less *objective* and therefore increasingly susceptible to abuse.

There is certainly ample anecdotal evidence of medical prognoses about a terminal patient's life expectancy which have proven to be wildly inaccurate. John Tucker MHA provided his own mother's prognosis as one such example in his Second Reading speech to Parliament (Friday 4th December 2020) in which addressing this point, he succinctly stated, "My mother had a cancer diagnosis and was given six months to live but she survived for another six years. You need to experience death to begin to understand this issue." Indeed.

4. The Role of Doctors

This Bill dramatically alters the role of doctors and medical staff (nurses, paramedics, and allied health professionals). While Part 11, Section 63, article 1 (i) requires that doctors or nurses meet a minimum of 5 years experience and have completed the "approved voluntary assisted dying training course" … "which may be training provided by means of a computer" (Part 17, Section 116, 1) which must train a doctor or nurse in "identifying and assessing whether a person may be subject to abuse or coercion in making a decision under this Act" (Part 17, Section 116, 2.b), it is difficult to reconcile this required skill set with that of what medical doctors and nurses are trained to do — *care for the ill and the injured*. This enactment of this Bill jeopardises the trust that a patient should have in their doctor despite the provisions within the Bill for a doctor

not to initiate a discussion about the option of VAD (Part 4, Section 17, 1). The inability to practically police this provision puts doctors and nurses in a very vulnerable position of false accusation from family members.

Recommendations

We encourage the Panel to advise the Tasmanian Parliament to consider the many unintended consequences of this Bill and to recommend an authentic list of end-of-life choices for Tasmanians. These recommendations should address the allegations raised in the Legislative Council that palliative care in Tasmania is failing (or is perceived to be failing) those Tasmanians who have reached the end of their lives. This should at least include the implementation of the *2017 House of Assembly Standing Committee on Community Development, Inquiry into Palliative Care* recommendations which would include dedicated Palliative Care Units, the appointment of specialist Palliative Care medical staff, and the funding of Palliative Care support through our public hospitals. This, at least, should be done *first* so that Part 4, Section 17, 2b of the Bill can be taken seriously, "The medical practitioner also informs the person about –

> (b) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment."

This Bill puts Tasmania's vulnerable: *the elderly, the terminally ill, the mentally ill and demoralised, and medical staff including first-responders* at risk in different ways and invites a host of unintended and negative consequences. Thank you for your consideration.

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