A SUBMISSION IN RESPONSE TO
"VOLUNTARY ASSISTED DYING: A PROPOSAL FOR TASMANIA"

VOLUNTARY ASSISTED DYING

A FLAWED PROPOSAL FOR TASMANIA

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(DIOCESE OF TASMANIA)

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This submission is a response to the consultation paper *Voluntary Assisted Dying: A Proposal for Tasmania* which was released by the Premier, Lara Giddings, and the Leader of the Greens in the Tasmanian Parliament, Nick McKim, as Private Members.

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Terminology

"VAD"	"Voluntary Assisted Dying" the form of euthanasia being proposed in the consultation paper.
"The VAD Paper"	The consultation paper, *Voluntary Assisted Dying: A Proposal for Tasmania*
"The Members"	The Hon. Lara Giddings and The Hon. Nick McKim who are making this proposal as Private Members of the Tasmanian Parliament
'The 1998 Inquiry'	The inquiry made by the Community Development Committee of the House of Assembly of the Tasmanian Parliament which produced *Report on the Need for Legislation on Voluntary Euthanasia* in 1998

Scope

The consultation paper *Voluntary Assisted Dying: A Proposal for Tasmania* outlines a proposal which would introduce state-sanctioned euthanasia into the State of Tasmania. This proposal would allow Tasmanians in certain circumstances to have their life ended by the administration of lethal medication.

The Voluntary Assisted Dying (VAD) paper, while seeking feedback on one particular system of euthanasia, presumptively ignores the principle questions of efficacy and benefit. The discussion questions included in the paper make this presumption.

It is the principled issues which are of greater concern. This submission therefore does not interact with the questions presented in the VAD paper, except by way of considering the flawed premise on which they are based. However responses are invited to "any other aspect" of the VAD proposal and it is this, the broader question, which is addressed in this submission.

SUMMARY

1 THE VAD PAPER: UNASHAMEDLY PREJUDICED

1.1 IGNORING THE MAIN QUESTION

Ms. Giddings and Mr. McKim ("the Members") propose a system of euthanasia which they have called "Voluntary Assisted Dying" ("VAD"). This proposal has been encapsulated in a consultation paper ("The VAD Paper"). It is an undisputed fact that this paper is prejudiced in favour of euthanasia.

A pre-judgement has been made on the fundamental question of whether or not a system of euthanasia should be introduced into Tasmania.

One of the proposing members, Mr. McKim, has been quoted in the media as saying

> *"Rather than seeking a discussion on whether or not we should introduce voluntary euthanasia, it will be encouraging discussion around how it should be done...*
>
> *"We will then draft and table legislation that is appropriate for Tasmania, which gives it the best chance of passing the Parliament."*[1]

It is clear that the Member has made a predetermination that euthanasia *should* be introduced to Tasmania. He is only open to discussing the form it might take.

The foreword to the VAD paper echoes this sentiment and relegates the fundamental question to the merely "theoretical" while the secondary question is characterised as "practical."[2]

The fundamental question is about whether or not the state should be an active agent in the intentional killing of any of its citizens. This is very much a "practical" question. It is a matter of life and death!

The prejudice of the VAD paper is apparent in a number of ways

1. Unquestioning use of sources.
2. The misuse of data and poor logic.
3. Misunderstanding the opposing arguments.
4. Unsound notions of human life, the nature of care and compassion, and the role of government in society.

These areas of concern will be considered throughout this submission.

1.2 DOUBLE STANDARDS

It should be noted that the Members are derisive of those who offer arguments against their pre-judged position. They make a number of accusations regarding the quality of the argument and material apparently used by those who disagree with them.[3]

Such claims are impossible to refute because the Members do not apply these accusations specifically. There are no substantial quotations or citations of the errors they have found so that others may consider the veracity of their judgement.

Their accusation of poor standards can therefore not be tested. This in itself is an extremely poor standard to set and it is justifiable to consider their accusation as hypocritical. The Members seem to set standards which they do not apply to themselves. Double standards are destructive to the health of dialogue.

Without being able to address the Members specific concerns through clarification and elucidation this submission must concentrate

on highlighting the weaknesses in the Member's position.

1.3 A BIASED PROCESS

The definitive examination of euthanasia in the Tasmanian Context is the inquiry made by the Community Development Committee of the Tasmanian House of Assembly into "*the Need for Legislation on Voluntary Euthanasia."* This inquiry reported in 1998. Its findings are based, in general, on a thorough and balanced consideration.

A key principle articulated by the 1998 Inquiry warrants particular emphasis. The Committee found that "*the obligation of the state to protect the right to life of all individuals equally could not be delivered by legislation that is based on subjective principles*"[4]

The VAD proposal, at its core, depends on subjective principles. This is an example of how the VAD proposal is directly antagonistic to a number of the in-principle findings of the 1998 Inquiry.

Rather than seeking to engage with this basic principle of governance, the Members presenting the VAD paper simply dismiss the conclusions of the 1998 Inquiry as out of date[5] and simply assert that there is no need for an in-depth inquiry.[6]

They consider the rightness of euthanasia to be self-evident. They are willing to bypass proper scrutiny and present the VAD proposal with tones of *fait accomplis*.

There are more appropriate ways for the Members to advance their cause. The appropriate way to revisit the findings of a Parliamentary Committee with new evidence is to re-form an Inquiry, with similar terms of reference, and with similar authority, to review the findings in the light of that new evidence.

The VAD paper could be taken as an appropriate *submission* to such an inquiry, were it to be held. But it cannot and should not be held to be on a par with a proper inquiry. Sadly, the VAD paper is not the fruit of a balanced consideration, and is of sufficient qualitative inferiority as to fall well short of that mark.

Since 1998 there has been no equivalent inquiry. The 2009 inquiry by the Joint Standing Committee on Community Development into the euthanasia bill presented in that year did not, as the Members themselves observe, "resolve the substantive issues"[7]

To advance simply through a call for comments on a non-authoritative paper written by Private Members of Parliament with a clear prejudice on the issue at hand is simply not adequate.

By doing so, the Members are failing to take the issue seriously, they are failing to either understand or respect the views of those who differ from them, and they are embracing imposition rather than conversation. This is the path of belligerence rather than civil discourse.

The Members must be under no misapprehension here: the burden of proof rests with them. The possibility of implementing euthanasia in Tasmania is not a certainty requiring final obstacles to be overcome; it is a significant change in the fundamental relationship between the state and its citizens. Such ground breaking change should not be considered without care and reasoned justification.

The VAD paper neither demonstrates the necessary care, nor makes the necessary justification for such change.

2 THE ANGLICAN CHURCH AS RESPONDENT

The Anglican Diocese of Tasmania is a part of the Anglican Church of Australia and is a Christian religious body geographically coterminous with the State of Tasmania.

The Diocese of Tasmania consists of approximately 50 parishes and districts[8] as well as operating in areas of special need including hospital and prison chaplaincies.

Over 128,000 Tasmanians (26% of the population) identify themselves as Anglican.[9] Anglicans are represented in virtually every aspect of society and in every profession.

Anglicans in Tasmania are well aware of the realities of human decline and death. This awareness comes from daily life, the work place experience of Anglican citizens involved in medical and related professions, and engagement with the hurting and bereaved through pastoral care and the exercise of Christian ministry.

In 2012 the Synod of the Diocese of Tasmania, the main instrument of authority for the diocese, consisting of over 200 lay and clerical members from across the State passed the following motion:

> *...that this Synod, recognising the likelihood of legislation being brought to the Tasmanian Parliament that would implement Assisted Suicide (also called 'euthanasia') reaffirms that any such legislation is unsafe, unnecessary and untested; being detrimental to a healthy society and the well being of the vulnerable and elderly in our society: and*
>
> *(a) calls upon the members of the Tasmanian Parliament to oppose any such legislation;*
>
> *(b) requests the Bishop to provide to Parishes relevant information about this issue, including the opportunities for the Christian voice to be communicated to Parliament; and*
>
> *(c) requests the State Government to devote more resources to the provision of palliative care throughout Tasmania.*

This motion reflects the mind of Synod and reaffirms the long-held position of the Anglican Church with regard to systems of euthanasia.

This position was clearly articulated to the 1998 Inquiry:

> *The Anglican Church is not opposed to allowing people to die when there is no possibility of that person recovering to live a meaningful life. Nor is the Church opposed to the administration of drugs for the relief of pain but which may also have the effect of shortening life.*
>
> *The Church is opposed to active euthanasia, that is, when other people decide to terminate a person's life either against the will of the person, without their consent or where a person has requested assistance to die.*
>
> *Three basic theological themes underpin the church's concerns. The first is the Christian affirmation of the sanctity of life. Secondly the church affirms that all of life is connected or related and denies the radical individualism and autonomy which underlies much of the argument supporting active euthanasia. Thirdly a theological view of suffering has an important place in the discussion.*[10]

Nothing has occurred since the 1998 Inquiry that would suggest a need to change this position.

3 FLAWS IN THE VAD PHILOSOPHY

3.1 MISREPRESENTING COMPASSION, MISHANDLING AUTONOMY

If there is a governing principle enshrined in the VAD paper it is articulated by a simple heading: “A compassionate response to suffering: choosing the manner and timing of one's death.”[11]

While such a statement has a sense of propriety and virtue it disguises a concerning misunderstanding of the nature of compassion, and a misappropriation of the value of autonomy.

Moreover, it demonstrates a careless oversimplification by the Members. The Members’ assertion is *self-contradictory* within the framework of the VAD proposal. The Members cannot, on the one hand, assert “choosing the manner and timing of one's death” as the touchstone of compassion, and then on the other, spend the bulk of their proposal considering the criteria which would *limit* eligibility for exercising that choice!

While it is gratifying that the Members are not proposing a laissez-faire “euthanasia-on-demand” model, they cannot give an adequate philosophical boundary to their assertion that compassion equals autonomy. They are therefore ill prepared to give a defence, (beyond mere political practicality of not scandalising the populace with something too radical), as to why they have included *any* of their criteria for restricting the eligibility of people for VAD.

After all, if VAD expresses autonomy which expresses compassion; why should anyone be prevented from accessing it? On what principled basis do the Members propose such discrimination?

If the Members cannot clearly articulate and grapple with these fundamental concerns, how can there be any confidence in the conceptual integrity of the VAD proposal at all?

Through VAD the State of Tasmania would be recognising personal autonomy (the “choosing the manner and timing of one's death”) as absolute, and its restrictions, while presented as apparently necessary, would be basically artificial. It is therefore extremely unlikely that any subsequent review of VAD would strengthen the restrictions. Rather, the loosening of eligibility requirements, for which there is clear *prima facie* evidence in other jurisdictions, would be almost certain in Tasmania.

Prima facie concerns from other jurisdictions include the following examples:

- In January 2013, the death by lethal injection of two middle-aged twins in Belgium who did not suffer a terminal illness, but who were going blind.[12]
- A current debate, also in Belgium, to extend the eligibility for euthanasia to minors and to those suffering senility, being argued for on the basis that it is “happening already.” This argument is identical to that used by the Members proposing VAD for Tasmania.[13]
- The approval of euthanasia for a person with severe senility in The Netherlands in November 2011, in the face of a requirement for mental competence.[14]

Tasmanians aspire to the effective exercise of compassion and care towards those who are in vulnerable circumstances.

The Members' philosophy, in its mishandling of the societal virtue of personal autonomy, does not advance this aspiration, it hinders it.

AUTONOMY VIOLATING LIFE

A tolerant and democratic society is shaped by a number of values and rights. Some values are held to be absolute; we associate these with "human rights."

The VAD paper mishandles one particular value: personal autonomy. To be sure, personal autonomy is something to be valued in society. Freedom of movement, freedom of conscience, freedom of religion, freedom of association and other freedoms all depend on this value.

Personal autonomy is not, however, an *absolute* value. People have freedom to choose, but choice is to be exercised within a context of obeying the law, respecting relationships and other people, and being considerate of community norms and expectations.

This is a basic understanding of human community. It has been articulated in many ways: For example, "Do what you want, unless it impacts others", and even, "Do unto others as they would do unto you."

Human beings are not simply geographically coincidental individuals. We live in community, in which interdependence and mutuality are simple facts of life. Without this understanding, the overemphasis of autonomy would move society away from interdependence and towards a rampant (some would say totalising) individualism.

It is inappropriate to speculate on the personal beliefs of the Members. Nevertheless, such individualism is apparent in this and other areas of social reform that they have proposed. Before they quickly warn others of imposing personal philosophical frameworks, they should consider their own neutrality.

The VAD proposal fails to recognise that the provision of euthanasia does not just affect individuals, but through human interdependence, it affects us all.

For instance:

- The decline and death of an individual affects many who are connected to that individual, particularly the next of kin. The VAD proposal only pays lip service to these relationships.[15] Neither does it recognise the possibility of these relationships presenting an element of coercion onto the patient.
- The request for euthanasia cannot be a purely private matter. It is a request by someone for *others* to be active agents in the administration of lethal medication. Moreover, the determination of whether such a request will be heeded would be made, not by the individual, but by *others*. The VAD proposal so emphasises providing an individual with the option to receive VAD that it fails to recognise or appreciate the effect on the surrounding relational and professional connections.
- The introduction of euthanasia does not just impact the individual, but the wider public. The VAD proposal makes much of the fact that no one will be compelled to either request or provide voluntary assisted dying. However, the existence of VAD would change the very nature of the health system. Would a citizen be able to avail themselves of hospital or other medical care in which they could be certain that a request for euthanasia would be refused? Under the VAD proposal, those who appreciate and desire a health system that would protect their

> life, being even protected from themselves, would no longer have that option. By giving the VAD choice to one individual the options are reduced for others.

It appears that the VAD proposal does not engage with the reality of how communities and relationships actually work.

Above all, however, the VAD paper mishandles the value of personal autonomy by placing it over and against a more fundamental value: the "inviolability" or "sanctity" of life.

As a Christian organisation the Anglican Diocese of Tasmania embraces the sanctity of life as a thoroughly biblical notion. We hold that human beings are made in the image of God and every person therefore has absolute innate value and meaning.

The Members proposing VAD are quick to negate the value of the sanctity of life as an inappropriately religious argument.[16] But that is a position that is is both credulous and specious. The "sanctity of life" is a value that is embraced by billions of people, across different religions and philosophies, including that of secular thought.[17]

By so quickly relegating this value, the Members have embraced a false dichotomy that places the right to "personal autonomy" at odds with the inviolability of life.

The relegation of the inviolability of life leads away from compassion.

Consider the characteristics of healthy, compassionate society: Personal autonomy is naturally restricted and respects the interdependence of community, and the state is bound to never violate life itself. In such a society compassion can exist at the deepest level.

Conversely, a society that embraces absolute free choice, and does not guarantee to protect the inviolability life, is clearly on a negative and uncaring path in which compassion plays no principal part.

The Members speak shallowly about the deep things of life.

SIMPLISTIC ABOUT SUFFERING

True compassion responds to suffering. True compassion acknowledges the interdependence of humans in community; the suffering circumstances of one person leads to a response from others.

Forms of suffering at the end-of-life include physical pain, and also existential pain which involves the loss of meaning or sense of worth.

Suffering at the end of life can involve *physical pain.* A compassionate response to physical pain is to provide for the relief of that pain. This is best provided through medical services that specialise in the relief of pain. This speciality is palliative care.

In order to justify the VAD proposal the Members have attempted to demonstrate shortcomings in palliative care. They overstate their case. The specialists with the expertise necessary to make such an assessment are quite clear: It is possible to effectively control pain, although some forms of pain control, in a minority of situations, may require a significant reduction in alertness or consciousness..[18]

Palliative care is the best and most effective way of responding compassionately to those who are in physical pain and it should be properly resourced. This resourcing is what our State Government should be governing.

Suffering at the end of life can also relate to existential notions: *"quality of life", dignity, and*

meaning. Proponents of euthanasia often refer to circumstances where life has become, in their view, “meaningless” or lacking in “dignity” or “quality.”

Just as the compassionate response to the suffering of pain is pain relief, the compassionate response to the experience of meaninglessness and indignity is to affirm personhood and innate value, and to do so irrespective of a person's circumstances. A compassionate response seeks to articulate and communicate meaningfulness and worth in all circumstances.

In contrast, the VAD proposal involves a determination that a person has “enough” futility or lack of quality. This is a callous judgement on a category of citizens.

3.2 DESTRUCTIVE IMPLICATIONS

The impact of a regime for euthanasia cannot be confined to the realm of independent choice. When considered in the real world, rather than in isolation, some negative implications are apparent.

Two examples of this are considered here. These do not exhaust the concerns, but illustrate them.

The first example considers the implied value judgements inherent to euthanasia. The second example considers euthanasia as it interacts with economic realities.

IMPLIED VALUE JUDGEMENTS

The present situation, in which euthanasia is prohibited, expresses equality. The state will not be an agent in the death of any citizen. In fact, the state will strive to protect the life of all its citizens equally.

The implementation of euthanasia creates two categories of citizens. The first category of citizens – those who are *not* eligible for euthanasia – enjoy the current protections. The second category of citizens – those who *are* eligible for euthanasia – have a modified form of protection that is dependent upon subjective assessment of wellbeing.

The demarcation connotes a value judgement. Those who are of the eligible category are considered to be suffering enough, or lacking enough dignity, that the state would be willing to terminate, not protect them.

“Eligible for eutthanasia” would be an abhorrent stereotype engrained into the very relationship between state and citizens as it communicates the negative and deadly value judgement: “Terminally ill people lack dignity”; or “Those suffering great pain do not have anything to live for.”

It is not surprising that many disability rights groups consider euthanasia to be deleterious to their efforts to be included in society as full citizens, enjoying the dignities and protections of all.

The American rights group *Not Dead Yet* makes the following points in response to the situation in Oregon:

> *...Disability concerns are focused on the systemic implications of adding assisted suicide to the list of “medical treatment options” available to seriously ill and disabled people....*
>
> ***The disability experience is that people who are labeled “terminal,” predicted to die within six months, are – or will become – disabled...***
>
> *Although intractable pain has been emphasized as the primary reason for enacting assisted suicide laws, the top five reasons Oregon doctors actually report for issuing lethal prescriptions are the “loss of autonomy” (89.9%), “less able to engage in activities” (87.4%), “loss of dignity” (83.8%), “loss of control of bodily functions” (58.7%) and “feelings of being a burden” (38.3%)... These are disability issues...*

In a society that prizes physical ability and stigmatizes impairments, it's no surprise that previously able-bodied people may tend to equate disability with loss of dignity. ***This reflects the prevalent but insulting societal judgment that people who deal with incontinence and other losses in bodily function are lacking dignity.*** *People with disabilities are concerned that these psycho-social disability-related factors have become widely accepted as sufficient justification for assisted suicide...*

In judging that an assisted suicide request is rational, essentially, doctors are concluding that a person's physical disabilities and dependence on others for everyday needs are sufficient grounds to treat them completely differently than they would treat a physically able-bodied suicidal person. [19]

CRUEL REAL CHOICES

The Members trumpet increased choice as a virtue of VAD. However, real choices take place in the real world.

VAD would ostensibly increase choice for patients. However, if currently implemented in Tasmania, the VAD choice would *not* be the choice between either lethal medication or effective palliative care; it would be a choice between lethal medication and poorly resourced, geographically distant palliative care after a long wait for therapeutic treatment. The stark reality of this choice, in itself, lacks compassion.

VAD would also increase choice for the providers of health services in Tasmania. The implementation and administration of VAD would require decision-making and resourcing by, presumably, the Department of Health and Human Services. It is simply a matter of economic reality that the provision of VAD would have an opportunity cost in the reduction of resources for remedial and palliative medical services. Promises by the Members that reductions would not occur are ignorant of the state's scarce financial resources and resultant pressures on the state's health budget.

Those suffering at the end of life in Tasmania should find compassion in well-resourced pain relief and palliative care. It is not compassionate to respond by additionally pressurising the Tasmanian health system with a proposal that is ostensibly a cheaper and easier option.

The Members have not addressed this concern professionally. They have made no effective financial analysis. They have presented no realistic costing – either relative to the health system or in absolute budgetary terms. There has been no real attempt to consider economic circumstances and to the extent to which they are coercive, particularly in remote, rural, and underprivileged areas of Tasmania.

A clear commitment to the provision of palliative care is needed in Tasmania. While there is a demonstrable lack of expedient provision for medical treatment – even remedial treatment – the proposition of a system of euthanasia is not only lacking compassion but bordering on the abhorrent.

4 FLAWS IN THE VAD PAPER

4.1 UNQUESTIONING USE OF SOURCES

In the formulation of the VAD paper the Members cite their reliance on a number of souces:

> *...the Royal Society of Canada, the Commission on Assisted Dying in the United Kingdom, the select committee report undertaken by the National Assembly of Quebec and the judicial decision in Carter v. Canada*[20]

There are other commentators that have pointed out the flaws[21] in a number of these sources. This submission does not claim to have the expertise to assess the veracity of these claims. The burden of due diligence, however, belongs to those who are proposing VAD and when sources are called into question, they should be assessed.

There are certainly questions surrounding the use of the judicial decision in Carter v. Canada in the VAD paper. Virtually all the references to this case appear to be recitations of pro-euthanasia expert witnesses such as Ann Jackson[22]. Moreover, the case itself is being appealed by the Government of Canada on a number of issues, including constitutionality and the proper role of government.[23] These are considerations which the Members should clearly take into account.

There are concerns, also, with the sources used in the VAD paper to back up the claim that euthanasia has popular support.

The Members claim “no matter how the question is asked, in reputable opinion polls the result is consistently and overwhelmingly in support of a last resort option for the patient’s doctor to be legally allowed to provide assistance to help the patient die.”[24] The sources that are cited consist of two polls commissioned by pro-euthanasia “Dying With Dignity” groups[25] that ask the same question in a form that communicates an assumption in its premise.

There is no consideration of situations where euthanasia frameworks have been rejected when placed before a popular vote, most recently in the American State of Massachusetts.[26]

Similarly, while attempting to assert that end-of-life situations currently exist in a place of legal uncertainty the Members are ready to quote from sources that they might otherwise reject as “unsubstantiated anecdote”.[27] But they pay no heed to the finding of the 1998 Inquiry which recognised with great certainty that:

> *...a doctor was not legally culpable for manslaughter or murder if his intent in withholding or withdrawing medical treatment from a patient who subsequently died was to relieve the patient of the burden of futile treatment in accordance with prudent medical treatment. Likewise the administration of sedative and analgesic drugs to terminally ill patients for the relief of pain and suffering even when it is foreseeable that such action will shorten life is not illegal whilst the intent is to provide palliation and not to deliberately kill the patient.*[28]

4.2 MISUSED DATA, POOR LOGIC

There are number of places in the VAD paper which exemplify the Members' own

accusations of “cherry-picking of information in a piecemeal way providing a distorted picture” and logical fallacies.

An example is their use of Kuhse et al.[29]

As an aside, it should be noted that this report would be rejected as being “from the 1990s... now well out of date”[30] if it had been used by those who disagree with the Members' position.

The Kuhse report is used to justify the assertion that euthanasia is an existing widespread unregulated practice. The data from the Kuhse report is presented as if to show that something in the order of 30-60% of deaths involve intentional ending of life.[31]

In reality, if the data are considered: 30.9% are “double-effect” deaths from palliative care in which pain relief may have hastened death; this is a practice not under dispute. 28.6% relate to the removal of futile treatment, which also is indisputably good current practice. 3.5% relate to unrequested involuntary euthanasia, which is a situation the VAD proposal does not wish to promote. This leaves only 1.8% of deaths as of real relevance to the VAD proposal. This is a vastly different picture to what is presented by the Members.

Another example is an attempt to justify the assertion that euthanasia does not lead to a breakdown in the doctor-patient relationship. The Members appeal to an absence of information: “We are not aware of any evidence that this damage has occurred...”[32] The data they do provide relates to comparative expressions of trust across professions. This does not consider change in doctor-patient relationships across the time of introducing euthanasia. Nor is there any in-depth investigation into data such as changes to hospital admittance rates, or qualitative considerations of how different areas of the health system were considered by the patients. An argument from silence is the chief of fallacies.

Finally, there is a strange logic that puts forward two apparently mutually exclusive assertions. Firstly, that doctors are currently providing euthanasia[33] despite the current prohibition. Secondly, that “effective safeguards can be achieved.”[34]

There is a clear sense in which both cannot be true. Safeguards as an effective mechanism rely on the adherence of medical professionals. If medical professionals are unwilling to adhere to current safeguards, why would we expect adherence to the proposed safeguards?

Similarly, the conclusion that current unregulated euthanasia should lead to legalised regulation is ill-conceived. It could more easily be concluded that current unethical behaviour requires a strengthening of accountability practices.

4.3 OPPOSING ARGUMENTS MISUNDERSTOOD

The VAD paper references four arguments against euthanasia reform; the sanctity of human life, the 'slippery slope' argument, the effect on the doctor-patient relationship and the adequacy of palliative care.

As has been noted earlier in this submission, the concept of the sanctity of human life is too quickly dismissed as a non-secular argument and the inadequacies of palliative care are overemphasised by the Members.

The doctor-patient relationship issue is only considered in minimalistic terms, and, as mentioned in the previous section, an argument from silence is employed.

The consideration of the “slippery slope” argument is also flawed in the VAD paper in that the Members fail to grasp the depth and breadth of the argument.

For instance, the concern that "weaker members of society would be made more vulnerable"[35] is handled by employing statistical consideration of euthanasia rates.[36]

The concern, however, cannot be addressed by such data. The slippery slope argument does not rely on a notion of "vulnerable" that fits the stereotype of elderly, infirm, or poor. Indeed, one could argue that a poor person with strong family ties is less likely to be vulnerable to coercion than the rich person with a family willing to fight over the imminent inheritance.

In another example, the VAD paper posits a strange hypothesis about the concern that legalised voluntary euthanasia would lead to involuntary euthanasia. They posit that this argument can be disproved if it can be shown that involuntary euthanasia exists in places other than those with a legalised euthanasia framework.[37] This misunderstands the causation at work.

The argument is not that legalised voluntary euthanasia directly *causes* involuntary euthanasia. The causes of medical killing without consent are many and varied, deriving from specific circumstances and contexts. The argument more readily posits that legalising voluntary euthanasia changes the environment such that cases of involuntary euthanasia are harder to prevent and harder to scrutinise.

Other aspects of the slippery slope argument which do not deal with voluntariness or coercion, such as the concern about broadening the eligibility criteria, are not properly considered.

5 FLAWS IN THE VAD SYSTEM

5.1 SUBJECTIVE SAFEGUARDS

The bulk of the VAD paper is a presentation of a particular system of voluntary euthanasia.

No system of voluntary euthanasia can be truly safeguarded. Systems for euthanasia are literally fatally flawed. Euthanasia removes the state's responsibility to guard the absolute inviolability of its citizens' human life. That fatal flaw cannot be fixed by mitigating mechanisms such as so-called "safeguards."

Any system of euthanasia that purports to be anything more than "euthanasia on demand" must propose *criteria* by which a person might become eligible for euthanasia. The VAD proposal is shaped around the consideration of certain criteria such as age, residency, mental competence and medical condition.

The VAD paper therefore raises questions that are necessarily moral and ethical. e.g. Is it wrong to offer VAD to someone under a certain age, and if so, why, and what age should that be? Is it wrong to provide VAD to someone who cannot explicitly request it, if so, why, and in what circumstances? Is it wrong to offer VAD to someone who is not terminally ill, and if so, why, and what level of illness makes the offering of VAD "right"?

In their proposal, the Members attempt to give their answer to some of these questions. Notwithstanding their desire to receive feedback and thus be open to certain minor changes, their consideration is piecemeal with no clear guiding principle for justifying the existence of the various criteria.

The main concern is this: It is unrealistic for euthanasia eligibility criteria to be anything but subjective.

When eligibility is based on subjective considerations, the state's commitment to the protection of a person's life is also made conditional on subjective considerations. It is in this circumstance that "*the obligation of the state to protect the right to life of all individuals equally"*[38] cannot be delivered.

The discussion in the VAD paper itself demonstrates this subjectivity.

5.2 UNREALISTIC CRITERIA

THE COERCION CRITERIA - VOLUNTARINESS

The Members wish to construct a system that embraces "voluntariness" in order to mitigate the possibility of influence or coercion on a person to request euthanasia.

This is a worthy aim. But the concern is clear: How is it right to consider euthanasia if "voluntariness" is *ever* in doubt?

The VAD paper attempts to demonstrate how bureaucratic processes and paperwork can eliminate this doubt. Be alert! Scepticism is warranted.

The situation in the Netherlands is revealing. The Members recognise that the Netherlands have a system which, similarly to the VAD proposal, demands that "The patient's request must be voluntary."[39] However, a well-respected report[40] in the prestigious medical journal, *The Lancet,* demonstrates how voluntariness has not been guaranteed in that jurisdiction.

The Lancet report notes that the "ending of life without explicit patient request" occurred in 2010 at a rate of 0.2% of all deaths in the Netherlands. If this had been the

circumstance in 2010 in Tasmania, which experienced 4269 deaths,[41] at least 8 persons would have had their life ended without their explicit request. Is this acceptable for Tasmania? Such an occurrence would be an outrageous scandal.

THE INABILITY TO CHOOSE CRITERIA - MENTAL COMPETENCE

Similarly, the Members desire a system that ensures that only "mentally competent" patients can access euthanasia. In particular, they are rightly concerned about those with "impaired decision-making due to psychiatric or psychological disorder or depression."[42]

The members themselves raise the vexed question of depression and dementia. Clearly, they find the notion of providing VAD to those who have severe mental illness or senility as crossing some line of acceptability.

They are not able, however, to untangle the complexity of mental anguish, level of suffering, dependency, decision-making, and disability that pertains to an understanding of mental competence.

The issue of competence and consent has significant precedence when it comes to the question of offering therapeutic treatment.[43] In the case of euthanasia the application is much more fraught.

On the one hand, the Members are strict: They are willing to disallow Advance Directives, and so reject the principle that subsequent incapacity does not render a competent decision invalid. On the other hand they are lax: Mental competence is reduced to a clinical assessment, presumably of rational capacity. And the Members themselves then raise the question of senility and mental illness, implicitly recognising that the question is not just about rationality but also emotional and psychological stability.

The VAD proposal does not provide a pathway through this confusion. It does not even provide an adequate judicial or statutory framework within which new precedences might be set. The determination of the point at which mental competence is or is not of an acceptable level thus retains its essential subjectivity.

THE NOT SICK ENOUGH CRITERIA - NATURE OF ILLNESS

The VAD proposal attempts to restrict eligibility to those suffering terminal illness.

In this instance an assessment must be made on what is "incurable" and what it means to be in the "advanced stages" of a disease.

The Members themselves realise that there is no objective way to make this determination. They reject, for instance, arbitrary lines drawn with regard to estimated longevity.[44]

The defining characteristics are therefore encapsulated in vague notions of what is "unbearable and unrelievable."[45]

However, there is no direct correlation between a condition being "unbearable" and "unrelievable" and it also being "terminal."

Indeed, these attributes are inconsistent with the notion of "compassion" as it is expressed in the VAD paper. Consider two persons experiencing two "unbearable and unrelievable" conditions, which is judged terminal for one person but not the other. On what principled grounds would the Members withhold so-called "compassionate" VAD from the person who was not going to die from the condition, and allow it for the person who was going to die anyway?

We could expect, as has been the case in other jurisdictions, that despite any safeguards, there would be a push for the scope of euthanasia to broadly apply beyond situations of terminal illness.

There is no confidence that there can be a system adequately protected from such broadening if the proposers themselves are not able to articulate a robust principles for why and how the criteria are set.

6 RECOMMENDATIONS

The consultation process for this Voluntary Assisted Dying proposal is relatively informal. There is no formal inquiry and the Members requesting feedback are not bound by any obligation to consider or even report that feedback.

The Anglican Church of Tasmania may well have entertained the thought of not responding at all.

The Anglican Church of Tasmania has responded because it has a vision for Tasmania which is marked by a real compassion: A compassion in in which the "weak," "vulnerable," "unproductive," "burdensome," "inconvenient," and "broken" are affirmed in their worth and their personhood.

The Anglican Church in Tasmania therefore makes three recommendations:

6.1 RECOMMENDATION #1 – WITHDRAW THE PROPOSAL

The Members should withdraw the VAD proposal.

If they feel the need to pursue the legislative provision for euthanasia they should do so through the appropriate, transparent, accountable processes of the Parliamentary committee system.

The Members should cease using their privileged position as a mechanism for railroading reforms. If they truly believe that their proposal is reasonable and has popular support they should have no fear of it being properly scrutinised.

It is the view of the Anglican Church that the findings of the 1998 Inquiry are relevant and appropriate and no case has been made that the findings should be revisited, let alone reversed.

The Members may well be sincere idealists, but they fail to understand that in reality their proposal is a form of imposition. It is presented without mandate and demonstrates both a lack of due diligence and a lack of care. Any sense of aggrievement by Tasmanians that they are yet again being made subject to a potentially divisive debate when there has been no change in fact or relevant law is justifiable.

6.2 RECOMMENDATION #2 – IMPROVE THE HEALTH SYSTEM, ESPECIALLY PALLIATIVE CARE

The Members presenting this VAD proposal, who are also the incumbents of the privileged offices of the Premier of this State of Tasmania and a Member of the Cabinet of the State Government, should lead their Government to improve the health system and especially palliative care for all Tasmanians.

The problems with the Tasmanian Health System are well documented and well known.[46] The Members have a responsibility as political leaders to do all they can to ensure that basic remedial and palliative treatments are available to all Tasmanians at a reasonable cost, within a reasonable time, and within a reasonable distance.

The pursuit of VAD would place additional burden on the health system, and a possible detrimental coercion on citizens already made vulnerable by the poor provision of medical services.

While the health system remains under so much pressure the pursuit of VAD is not just a distraction but a shirking of Government

responsibility.

6.3 RECOMMENDATION #3 – IMPROVE AWARENESS ABOUT END OF LIFE CARE

It is clear from the VAD Paper that the Members are motivated in part by the desire to facilitate awareness and conversation about end-of-life issues.

This, in and of itself, is a worthwhile aim.

The 1998 Inquiry also recommended that attention be given to the information provided to those experiencing illness, death and bereavement.

> *6. The Committee recommends that patients have greater access to information*
>
> *about their rights regarding medical treatment..*[47]

Clearly, the improvement of the awareness of patient rights can be envisaged and recommended without requiring a euthanasia provision. The Members would do well to identify how this recommendation has been advanced since 1998 in its own right.

Any process for improving the provision of information, and recording and acting upon a patient's wishes is to be applauded.

Such a provision, however, can occur independently of any proposal for VAD, and should do so.

Euthanasia is not needed as an educational aid to speak about end-of-life issues. We can speak of end-of-life issues without the spectre of state sanctioned killing hanging over Tasmanians' lives.

1 Source: The Examiner, http://www.examiner.com.au/story/157059/assisted-death-debate-reignited/ June 24, 2012
2 The VAD Paper, Page 1
3 The VAD Paper, Pages 19-20
4 Parliament of Tasmania, House of Assembly Community Development Committee, *Report on the Need for Legislation on Voluntary Euthanasia* 1998: Findings, Page 2
5 The VAD Paper, Page 11
6 The VAD Paper, Page 7
7 The VAD Paper, Page 11, quoting Bartels and Otlowski
8 See http://anglicantas.org.au/parishes/
9 Source: 2011 Census data, see: http://www.censusdata.abs.gov.au/census_services/getproduct/census/2011/quickstat/6
10 Anglican Church of Australia, Diocese of Tasmania, Submission to the House of Assembly Community Development Committee Euthanasia Inquiry, June 1997, Pages 2 and 9
11 The VAD Paper, Page 9
12 Source: Reuters, http://www.reuters.com/article/2013/01/14/us-belgium-euthanasia-idUSBRE90D0W620130114, Jan 14, 2013
13 Source: AAP http://www.couriermail.com.au/news/breaking-news/belgium-debates-euthanasia-for-minors/story-e6freoo6-1226582346113, Feb 21, 2013
14 Source: Agence France-Presse http://news.nationalpost.com/2011/11/09/first-euthanasia-in-netherlands-of-severe-alzheimers-patient/ Nov 9, 2011
15 The VAD Paper, Page 57
16 The VAD Paper, Page 20
17 Crf. Article 3 of the Universal Declaration of Human Rights: ""Everyone has the right to life, liberty and security of person."
18 Dunne, P. *If Euthanasia is the answer, what is the question?* Presentation given at St. David's Cathedral Hobart, Friday Forum, Feb 17, 2012. http://saintdavids.org.au/event/2012/02/if-euthanasia-is-the-answer-what-is-the-question/
19 *Not Dead Yet Disability Activists Oppose Assisted Suicide as a Deadly Form of Discrimination,* http://www.notdeadyet.org/assisted-suicide-talking-points, accessed March 12, 2013, emphasis added.
20 The VAD Paper, Page 7
21 A very clear example is Schadenberg, Alex, *Exposing Vulnerable People to Euthanasia and Assisted Suicide*, Connor Court, Ballan VIC: 2013, a small monograph devoted to the critique of various studies in this field.
22 See the VAD Paper, Page 10
23 Source http://www.ccdonline.ca/en/blog/assisted-suicide-13July2012, accessed March 15, 2013
24 The VAD Paper, Page 18
25 Consider section "Survey Information", The VAD Paper, Page 105
26 Source: http://www.commonwealmagazine.org/blog/?p=21731, accessed March 13, 2013
27 The VAD Paper, Pages 13-14, and Page 20
28 The 1998 Inquiry Report, Finding #9, Pages 6-7
29 The VAD Paper, Page 13
30 The VAD Paper, Page 19
31 The VAD Paper, Page 13
32 The VAD Paper, Page 22
33 The VAD Paper, Page 10
34 The VAD Paper, Page 11
35 The VAD Paper, Page 21, quoting the 1998 Inquiry
36 The VAD Paper, Page 21
37 The VAD Paper, Page 22
38 Community Development Committee, *Report... on Voluntary Euthanasia* 1998: Recommendations: Findings, Page 2
39 The VAD Paper, Page 67
40 Onwuteaka-Philipsen et al, "Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey", *Lancet online*, July 2012
41 Source: ABS 3302.0 *Deaths, Australia*
42 The VAD Paper, Page 32

43 Consider for instance, Dondershine, Harvey, *Competency to Make Medical Decisions,* Paper from Seminar in Psychiatry and Law, http://forensicpsychiatry.stanford.edu/Files/Medical%20Competency.doc Accessed March 12, 2013
44 The VAD Paper, Page 40
45 The VAD Paper, Page 43
46 Consider a very recent example reported in the Mercury, “Our hidden sick list revealed”, http://www.themercury.com.au/article/2013/03/11/374305_todays-news.html, March 11, 2013
47 Community Development Committee, *Report... on Voluntary Euthanasia* 1998: Recommendations, Page 8