Analysis

of the

Voluntary Assisted Dying Bill 2013

sponsored by

Lara Giddings MP and Nick McKim MP

Email: premier@dpac.tas.gov.au

to

Members of the House of Assembly

assembly@parliament.tas.gov.au (03) 6212 2200

and

Members of the Legislative Council

council@parliament.tas.gov.au (03) 6212 2300

Parliament House, Hobart TAS 7000

by

FamilyVoice Australia

GPO Box 9894

Hobart TAS 7001

Telephone: 1300 365 965

Facsimile: 08 8223 5850

Email: office@fava.org.au

Website: www.fava.org.au

3 October 2013

TABLE OF CONTENTS

1. Introduction

On 27 September 2013 the Premier of Tasmania Lara Giddings MP and the Leader of the Tasmanian Greens Nick McKim MP tabled the *Voluntary Assisted Dying Bill 2013*[1] (hereafter referred to as "the Bill") in the House of Assembly.

Debate on the Bill is expected to begin on Tuesday 15 October 2013.

2. Explanation of some key clauses

2.1 Legalised murder

The Bill would legalise, in certain circumstances, acts that are currently crimes under Tasmanian law – namely murder or assisted suicide (Clause 4(2)).

Eligible persons may have their lives intentionally ended either by a medical practitioner administering a lethal poison or by a medical practitioner giving the person a lethal poison to self-administer (Clause 24).

If the lethal poison doesn't successfully kill the person, the Bill would appear to allow, and make lawful, any subsequent action by the medical practitioner to ensure the person died (e.g. suffocation), provided this had been agreed to by the person beforehand (Clause 12(3)(e)).

2.2 Death tourism

A person must be a "Tasmanian resident" when making each of three required requests for "assisted dying". A Tasmanian driver's licence is sufficient proof of residency (Clause 10).

According to a private communication with the Tasmanian Department of Transport, a person holding any Australian driver's licence can obtain a Tasmanian driver's licence on the day of arrival in Tasmania, provided there is some proof of a Tasmanian address such as a rent receipt.

The Bill would therefore effectively facilitate "death tourism". It would be very easy for an interstate resident to fly to Hobart and arrange euthanasia within 10 days of arrival.

<u>This Bill, if passed, would affect all Australians, not just Tasmanians</u>.

2.3 Eligibility: medical condition – terminal or progressive

A person must have a medical condition that is incurable and irreversible (Clause 11).

The condition may be either terminal, namely it "would result in the death of a person diagnosed", or progressive (but non-fatal) such as Parkinson's disease, rheumatoid arthritis or diabetes.

The medical condition must be persistent, not relievable, in an advanced stage, and must cause suffering that is intolerable for the person, with no reasonable prospect of permanent improvement (Clause 11).

Good palliative care can relieve pain and other symptoms that ordinary medical practitioners lack the skills and experience to achieve – but the Bill does not require the primary medical practitioner to consult a palliative care specialist.

"Suffering" is not defined and may include physical, psychological or existential suffering. Suffering is a subjective notion. It can depend greatly on factors such as depression, and be alleviated when the depression is treated and/or good palliative care is provided.

The medical condition may not solely be due to age, disability or psychological illness (Clause 11).

The use of the term "solely" here means that age, disability or psychological illness could be a contributing factor – *even the major contributing factor* – provided there was an aspect of the condition that was not solely attributable to one of these factors.

Thus people who are elderly or depressed or disabled may request and be deemed to qualify for euthanasia as long as they also suffer from some progressive condition and say they find life intolerable.

2.4 Eligibility: brief cooling-off period

The person requesting euthanasia is required to make three separate requests over a nine day period (Clauses 13, 17 and 21).

A person must make an initial oral request, followed (at least 48 hours later) by a written request and then (at least seven days later) a final oral request for "assisted dying". Immediately after this final oral request, the person may request the medical practitioner to prescribe the lethal poison. The script could be filled immediately and administered or given to the person for self-administration.

It could take just 10 days from a person first asking a medical practitioner about euthanasia to the person being killed by administration or self-administration of a lethal poison. This is too short a time to adequately assess this life-or-death situation, or to be sure that the person's euthanasia request is not due to depression or undue influence.

3. Ineffective safeguards

3.1 Referral for counselling to a psychologist or psychiatrist

The referral is only to assess whether the person is competent to make the request and is making it voluntarily (Clauses 14 and 15).

The referral is entirely at the discretion of the primary medical practitioner, who may not have the skills to determine whether such a referral is necessary. These clauses do not provide a reliable safeguard.

3.2 Specialist medical practitioner

The person must be referred to a secondary medical practitioner with "specialised qualifications, or experience, in diagnosing and treating the eligible medical condition of the person" for diagnosis and prognosis (Clauses 3(b), 19 and 20).

However, if the primary medical practitioner is not satisfied with the determination of the specialist or "experienced" general practitioner, another opinion can be sought from a second practitioner.

The Bill does not specify the degree of "experience" the secondary medical practitioner is required to have in treating a particular condition in order to qualify for providing a second opinion on a person's eligibility for assisted dying. The secondary medical practitioner may be an ordinary GP who has treated one or two similar cases. There is no absolute requirement for the second opinion to be provided by a specialist.

Moreover, the Bill would allow the primary medical practitioner to kill a person by administering a lethal poison, even though a specialist has determined that the person does not have the condition, or that the prognosis is not so bleak after all!

These clauses do not provide a reliable safeguard.

3.3 'Voluntary' requests

The primary medical practitioner could be the sole determiner of whether or not a request to be killed by lethal poison is made voluntarily (Clauses 10 and 23).

Subtle coercion of vulnerable people, including the elderly, the disabled and the seriously ill can be very hard to detect.

The Bill would severely penalise, with a fine of up to $26,000 and/or five years' jail, a person who coerces or exercises undue influence on another person to make a request for "assisted dying" (Clause 39) – but such coercion can be very subtle and unprovable.

The Bill would not ensure that such coercion does not happen. The Bill would even allow one of the witnesses to the written request to be a close relative or someone who could gain financially from the death of the person (Clause 17(5)).

These clauses cannot guarantee that euthanasia requests are "voluntary" – they are not a reliable safeguard.

3.4 Registrar

The Bill would require the Minister to appoint a Registrar who would be empowered to "review a death that occurs as a result of assistance provided under this Act, for the purpose of monitoring compliance with this Act" (Clause 32).

But if non-compliance is found at this stage, the discovery is no help to the person – who is, of course, dead!

The other major flaw is that so much of the compliance with the requirements of the Bill is dependent on the subjective judgement of the primary medical practitioner. Provided that medical practitioner (a) completes and files all the required paper work and (b) finds at least one specialist or general practitioner with some relevant "experience" (out of any two approached for an opinion) to back up the diagnosis and prognosis, it is hard to see how any non-compliance could be proved.

The compliance is determined by the primary medical practitioner's own report of his own actions. The other significant witness is no longer alive and able to comment. The compliance requirement is no safeguard at all.

4. Other serious flaws

4.1 False definitions

The Bill states: "Any action taken in accordance with this Act does not, for any purpose, constitute suicide, assisted suicide, killing, mercy killing, homicide, murder or manslaughter" (Clause 4(2)).

Dictionaries define suicide as "the action of killing oneself intentionally".[2] Thus actions taken by persons to intentionally ingest a lethal dose of poison provided by a medical practitioner clearly constitute "suicide" and "killing".

Actions taken by a medical practitioner to deliver a lethal dose of poison to a person with the intention of causing the death of that person also clearly constitute "killing" and "homicide".

The wording of the Bill is disingenuous, apparently designed to make its provisions seem less grave than they actually are.

4.2 Denial of right to conscience and religious freedom

The Bill would allow any health care provider to decline to participate in activities leading to the administration of a lethal poison to a person under the Bill (Clause 31(d)(2)).

A religious hospital would be allowed to prohibit medical practitioners from participating in such activities on its premises, or as part of providing services under contract to the hospital.

However, it would be unlawful for a religious hospital to terminate a contract or otherwise penalise a medical practitioner who participated in such activities on premises outside the hospital, or in addition to providing contracted services for the hospital.

A religious hospital with deeply held conscientious beliefs about the sanctity of life could be forced to continue to employ doctors and nurses who give lethal doses of poison to people on other premises.

4.3 Penalising suicide prevention

The Bill would make it an offence, subject to a $26,000 fine and/or five years' imprisonment, to exert undue influence in persuading a person to rescind a request for "assisted dying" (Clause 39).

Thus talking a spouse, parent or grandparent out of assisted suicide or euthanasia by lethal poison could land a person in jail.

Tasmania's Suicide Prevention Strategy 2010-14 states: "Fundamental to the successful implementation of this Strategy is acknowledgment that suicide prevention is everybody's business."

This strategy is contradicted by Clause 39 of the Bill, which provides an extreme penalty for preventing suicide via medical practitioner. Lifeline counsellors – beware!

4.4 No notification of family

The Bill requires the primary medical practitioner to "recommend' that eligible persons inform friends and family of their euthanasia request (Clause 14(f)), but does not make this recommendation mandatory, nor require the primary medical practitioner to contact family members.

Close friends and family members may know more than a primary medical practitioner (who is not required to have known the eligible person for very long) about the history of the person's medical condition and his or her mental competence to make a euthanasia request.

In April 2012, a Belgian woman was euthanased on the ground of chronic depression at a Brussels hospital. Her son, university lecturer Tom Mortier, writes:

> *I was not involved in the decision-making process and the doctor who gave her the injection never contacted me.*
>
> *Since then, my life has changed considerably. Up until now, I am still trying to understand how it is possible for euthanasia to be performed on physically healthy people without even contacting their children. The spokesman of the university hospital told me that everything happened according to my mother's "free choice". After my mother's death, I talked to the doctor who gave her the injection and he told me that he was "absolutely certain" my mother didn't want to live anymore.*
>
> *The death of my mother has triggered a lot of questions. How is it possible that people can be euthanased in Belgium without close family or friends being contacted? Why does my country give medical doctors the exclusive power to decide over life and death? How do we judge what "unbearable suffering" is? What are the criteria to decide what "unbearable suffering" is? Can we rely on such a judgment for a mentally ill person?*
>
> *After all, can a mentally ill person make a "free choice"? Why didn't the doctors try to arrange a meeting between our mother and her children? How can a medical doctor be "absolutely certain" that his/her patient doesn't want to live anymore?*[3]

Ignoring family members may lead to wrongful death and lasting grief.

4.5 Manipulation of life insurance

The Bill states: "The act of a person self-administering prescribed medication to end his or her life in accordance with this Act is not to affect any life, health or accident insurance, or annuity or policy that may be held in respect of the person (Clause 30(2)).

"The act of a person to end the life of another person in accordance with this Act is not to affect any life, health or accident insurance, or annuity or policy that may be held in respect of that other person (Clause 30(3))."

These provisions would enable a person to "rort the system" by taking out life insurance and soon afterwards receiving a lethal dose from a medical practitioner, enriching the beneficiary.

There could be a considerable negative impact on the life insurance industry if the Bill is passed.

5. The Nitschke factor

'Everyone has the right to die at any time': Dr Philip Nitschke

Australian medical practitioner Dr Philip Nitschke is on record as supporting the right of "troubled teens" and "the depressed" to access means to end their lives – and the duty of those with knowledge of these means, such as medical practitioners, to assist them.

> *… if we believe that there is a right to life, then we must accept that people have a right to dispose of that life whenever they want … So all people qualify, not just those with the training, knowledge, or resources to find out how to "give away" their life. And someone needs to provide this knowledge, training, or recourse necessary to anyone who wants it, including the depressed, the elderly bereaved, the troubled teen. If we are to remain consistent and we believe that the individual has the right to dispose of their life, we should not erect artificial barriers in the way of sub-groups who don't meet our criteria.*[4]

Any jurisdiction in Australia considering legalising euthanasia must anticipate that if euthanasia were to be legalised, it is highly likely that Dr Philip Nitschke would be among the first to take advantage of the new law by setting up a medical practice to facilitate assisted dying.

As demonstrated by the analysis of the deaths for which he was responsible in the Northern Territory when euthanasia was briefly legal there, the prospect of Dr Nitschke establishing a euthanasia practice in Tasmania should be cause for concern.[5,6]

Media reports on 18/12/2008 said Dr Philip Nitschke was promoting a device causing death by breathing helium – which he said had the "additional benefit of undetectability" in an autopsy.[7] This promotion effectively recommended the illegal action of assisted suicide, since a collaborator would be required to conceal the equipment and thus fool a coronial inquiry. Advocacy of fraud has no place in the medical profession.

Based on the case studies from the Northern Territory and on the subsequent behaviour of Dr Phillip Nitschke, it would be dangerous to legalise euthanasia in any jurisdiction where he, or any doctor sharing his approach to euthanasia, is licensed to practise.

6. Conclusion

The *Voluntary Assisted Dying Bill 2013* would, if enacted, fundamentally change the law in Tasmania to permit acts which are currently considered to be acts of murder or assisting a suicide.

The Bill 2013 has many serious flaws, including gravely inadequate safeguards against abuse.

The Bill is drafted so broadly that a person who had many years to live and who, on any objective test was not experiencing unrelievable pain, could be put to death.

The Bill would allow a depressed person or a person with a psychiatric disorder to be put to death.

The Bill would, if passed, impact the whole of Australia. It would be open to manipulation by euthanasia advocates. There is inadequate requirement for a second opinion or a cooling off period. There is no requirement for palliative care or family notification.

The Bill could foster a "culture of death" in Tasmania and the rest of Australia. The Bill could encourage depressed young people to consider suicide (without assistance) as a valid option to end their temporary emotional pain.

The Bill should be rejected.

7. Endnotes

1. Voluntary Assisted Dying Bill 2013, Tasmania: http://www.premier.tas.gov.au/__data/assets/pdf_file/0006/206547/Voluntary_Assisted_Dying_Bill_2013.pdf

2. See The Oxford Dictionary: http://oxforddictionaries.com/definition/english/suicide

3. Tom Mortier, "How my mother died", *MercatorNet*, 4 Feb 2013: http://www.mercatornet.com/articles/view/how_my_mother_died

4. Lopez, K, "Euthanasia sets sail: An interview with Philip Nitschke, the other 'Dr. Death.'", *National Review Online*, 5 Jun 2001: http://old.nationalreview.com/interrogatory/interrogatory060501.shtml

5. Kissane, D W, Street, A, Nitschke, P, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia", *The Lancet*, Vol 352, 3 October 1998, p 1097-1102.

6. Kissane D W, "Deadly days in Darwin" in *The Case Against Assisted Suicide*, K Foley & H Hendin (ed), Johns Hopkins University Press, 2002, p 192-209: http://www.aph.gov.au/senate/committee/legcon_ctte/terminally_ill/submissions/sub589.pdf

7. http://www.thaindian.com/newsportal/health/undetectable-suicide-device-to-be-unveiled_100132343.html .