Plunkett Centre for Ethics

A centre of Australian Catholic University located at St Vincent's Hospital Sydney

Submission re Terminally Ill Adults (End of Life) Bill: an Australian perspective.

House of Commons Public Bill Committee
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1. Authors and Summary

1.1 We, Xavier Symons and Bernadette Tobin, work at the Plunkett Centre for Ethics, a centre of Australian Catholic University located on the campus of St Vincent's Public Hospital in Sydney.

1.2 Our experience includes (a) commenting on proposed legislation in all Australian jurisdictions about what in this country is called 'voluntary assisted dying' (but should be called 'physician-assisted suicide/euthanasia') and (b) working with individuals and institutions whose view is that the procedures legalized by such legislation (i) do not belong to medical practice properly understood, (ii) are unnecessary when good end of life treatment is available and provided, and (iii) has a deleterious effect on the treatment and care of elderly, frail, sick and/or demoralized individuals.

1.3 We make this submission having conversed with Dr David Albert Jones of the Anscombe Centre in Oxford about the relevance of Australian experience to your deliberations.

1.4 **Summary:** In this submission we

- set out key differences between VAD in Australia and PAS in Oregon;
- show how the safeguards in Australian laws have been rapidly eroded;
- recommend the rejection of any amendments to your Bill that would weaken the requirement for self-administration or would extend the timeframe of six months;
- recommend the strengthening of provisions for conscience protections by reference to legislation in the United States (and not Australia); and
- recommend the committee pick up two safeguards found in some Australian legislation (but not in US legislation).

2. VAD in Australia is not like PAS in Oregon

2.1 Voluntary assisted dying (VAD) legislation and practice in Australia is very different from physician-assisted suicide (PAS) in Oregon and other jurisdictions in the United States.

2.2 Notably, of the seven Australian jurisdictions that have legalised VAD (Victoria 2017; Western Australia 2019; Tasmania 2021; South Australia 2021; Queensland 2021; NSW 2022, Australia Capital Territory (ACT) 2024), none restrict it to self-administration or to patients who are

expected to die within six months, whereas these are requirements in Oregon and in all ten US jurisdictions with PAS laws. In these respects, the Terminally Ill Adults End of Life Bill follows the Oregon model (S. 2(b), S. 18).

2.3 All Australian states allow practitioner administration (euthanasia) in some circumstances. This was allowed as an exception in Victoria (VAD Act 2017, S. 46(c)(i)), and South Australia (VAD Act 2021 (S. 64(c)(i)) only for people physically unable to self-administer, but other Australian states allowed practitioners to offer euthanasia wherever they deemed it appropriate and the Australian Capital Territory (ACT) simply allowed patients to choose between self-administration (assisted suicide) or practitioner administration (euthanasia) (VAD Act 2024 (S. 82(3)(c)).

2.4 Similarly, the law in Victoria made an exception to the six-month expectation of death and allowed 12 months in the case of neurodegenerative diseases (VAD Act 2017 (S. 9(4)), but Queensland later increased this to 12 months for all diseases (VAD Act 2021 (S. 10(1)(a)(ii)), and ACT has abandoned the requirement of a specific timeframe if a person is 'approaching the end of their life' (Act 2024 (S. 11(6)). The ACT legislation is very similar to the law in Canada in 2016, which only required that death be 'reasonably foreseeable'(Criminal Code 241.2(2)(d)).

3. Safeguards rapidly eroded

3.1 In these ways, and in many other ways, what were exceptions in the law in Victoria have gradually been expanded to become norms in other Australian jurisdictions, and requirements have been eroded. Where the law in Victoria is relatively close to the law in Oregon (and other US jurisdictions) the other Australian states have moved further from this model and the ACT law is closer to that in Canada (as it was in 2016) than to that in Oregon in 1997.

3.2 It should be no surprise that the numbers of assisted deaths in the first year in Australia jurisdictions have been much higher than in US jurisdictions. For example, in the first year in Oregon (p. 3) deaths by PAS were just 0.06% of all deaths, whereas the equivalent figure in Western Australia (p. 5) was 1.1% (rising to 1.6% in the third year (p. 6)), 1.2% in Tasmania (p. 4) and 1.6% in Queensland (p.1). These figures are all higher than the initial rate of medically assisted death in Canada. Note that 1.6% of the 581,363 deaths in England and Wales for 2023 would be 9,301 deaths, whereas 0.06% would be 349 deaths.

3.3 Similarly, the protection of institutional conscience, which exists in all US states with PAS exists in no Australian states. Nevertheless, at least in Victoria non-participating institutions were not penalised. In contrast most Australian states that later legalised VAD (South Australia, Queensland, NSW) have introduced requirements on institutions to participate in various ways, and ACT has criminalised operators of institutions that fail to promote VAD (with strict liability). In this respect ACT has gone further than Canada.

3.4 These incremental changes from the law in Victoria, to the laws in the other Australian states, to the law in ACT, have been advocated by campaign organisations (such as Go Gentle Australia), and by politicians and academics, as 'balancing access and safety'. However, the effect has been to subordinate safety to access.

3.5 The individuals and organisations that advocated for the sequential loosening of requirements in jurisdictions in Australia that have legalised VAD are now advocating for amendments to the laws in Victoria and Western Australia (and also in New Zealand) that would remove or further weaken safeguards in those jurisdictions.

3.6 The Committee should bear the above in mind when assessing submissions that cite the Australian experience, especially if these propose weakening the existing provisions in the Bill in the name of 'balancing access and safety'. In an Australian context this argument has been the rationale for moving further away from the Oregon model of PAS and approaching or even surpassing the model of medical assistance in dying in Canada.

4. Provisions of the Bill on timeframes and self-administration

4.1 In the light of the Australian experience, we strongly recommend that the Committee do not accept any amendments that would weaken the requirement for self-administration or extend the limit of six months.

4.2 In the light of the Australian experience section 18 does not seem adequate to prevent expansion of 'assisted dying' to include practitioner administration (euthanasia). In particular, the phase 'assist that person to… self-administer' (S. 18(6)(c)) is ambiguous. For example, if someone begins to self-administer by operating a medical device to inject the approved substance, but is unable to complete the action, would a doctor completing this action be assisting the 'self administration'?

4.3. Similarly, the stipulation that 'the final act of doing so must be taken by the person' (S. 18(7)) might be held to include assistance by a doctor completing the 'final act' which was initiated by the person.

4.4 The stipulation that the coordinating doctor is not authorised 'to administer an approved substance to another person' (S. 18(8)) is weakened by the qualification 'with the intention of causing that person's death'. If the doctor knowingly administers the approved substance to the person, then it is redundant to add 'with the intentional of causing the person's death'. Moreover, it may be misleading, as a doctor might argue that they administered the approved substance not with the intention of causing the person's death but with the intention of completing the act of self-administration by the person.

4.5 What is also lacking in the Bill is an overt statement of the legal consequence of practitioner-administration (euthanasia). Section 24(1) states that 'a person is not guilty of an offence by virtue of providing assistance to a person in accordance with this Act', and Section 24(3) states that it is a defence for a person charged with an offence under section 2 of the Suicide Act 1961 that they 'reasonably believed they were acting in accordance with the Terminally Ill Adults (End of Life) Act 2024' if they have 'exercised all due diligence'. However, the Bill is silent on whether the same considerations apply to the offence of homicide (murder or manslaughter), which is treated differently in law and in prosecution guidance from assisting suicide, and is a more serious offence that is more likely to be prosecuted.

4.6 Section 18(6)(c) should therefore be deleted, and Section 18(8) should be replaced with:

Nothing in this Act

(a) authorises a person to administer an approved substance to another person;
(b) provides a person who knowingly administers an approved substance to another person with a defence against prosecution for homicide, or,
(c) alters the prosecution guidance on whether 'acting in their capacity as a medical doctor, nurse, or other healthcare professional' to a person in their care is a reason in favour of prosecution for homicide.

5. Conscience clauses

5.1 No section of the Bill refers explicitly to 'conscience' or 'conscientious objection', though Sections 4 and 23 bear on the issue of conscientious objection.

5.2 As with Australian legislation, there is no overt protection in the Bill for private, charitable or voluntary aided health or social care providers such as hospices and nursing homes. The Australian experience is that without overt protection, the conscience rights of such institutions have been eroded further in successive laws, culminating in ACT which criminalises operators of institutions that fail to promote VAD. There has also been a sequential erosion of protection of individual conscience in Australian jurisdictions.

5.2 In this context we would strongly recommend that the Committee do not look to Australia but look to legislation in the United States to inform improvements to the conscience provisions of the Bill.

6. Other provisions in the Bill

6.1 While, in general, VAD legislation in Australia has fewer safeguards than similar legislation in the United States, two safeguards occur in Australian law but not in the United States, both of which are worthy of consideration.

6.2. The VAD Act of South Australia overtly states that VAD is not palliative care for the purpose of law or regulation (VAD Act 201 S.5). This provision prevents palliative care professionals from being expected to provide VAD and protects funding of palliative care from being diverted into VAD.

6.3 Under Section 1 of the Bill add

> *(3) For the purposes of the law, regulation and state funding, the provision of assistance in accordance with Act will be taken not to constitute palliative care of the person.*
>
> *(4) To avoid doubt, nothing in subsection (3) prevents a person or institution that is providing palliative care to a person from also providing assistance in accordance with this Act.*

6.4 Lastly, both the legislation in Victoria (VAD Act 2017, S. 8) and that in South Australia (VAD 2021, S. 12) prohibit healthcare professionals from initiating conversations about VAD. This provision has been controversial in Australia, but it has been controversial precisely because it has impeded the move towards the Canadian model of practice. In Canada VAD is actively promoted by governmental structures and health service providers and doctors are under an obligation to raise the subject with patients.

6.5 Replace 4(1) and 4(2) with

> *(1) A registered medical practitioner must not raise the subject of the provision of assistance in accordance with this Act with a person in the context of a medical consultation, unless the person has previously raised this issue with them or with another medical practitioner.*

(2) Nothing in subsection (1) prevents a registered medical practitioner responding to requests for information about the provision of assistance in accordance with this Act.

We trust that these remarks and suggestions will be helpful to members of the committee. We would, of course, be very happy to provide any additional assistance to the committee which may be helpful.

Yours faithfully,

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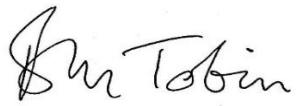

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