QUEENSLAND COUNCIL FOR CIVIL LIBERTIES

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Watching Them While They're Watching You

The Secretary
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
Parliament House
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Dear Sir

Thank you for the opportunity to make a submission in relation to this most important and controversial topic.

The Queensland Council for Civil Liberties is an organisation of volunteers founded over 50 years ago to protect the individual rights and liberties of Queenslanders.

In this submission the term voluntary assisted dying (VAD) covers both the case where a medical practitioner gives the medication to the person and they take it themselves (assisted suicide) and where the medical practitioner administers it, the latter is usually referred to as voluntary euthanasia.

This submission is restricted to addressing issues 25 to 38 in the Issues Paper. This is because the other issues are beyond the remit of the QCCL.

Basic principles

It is in our submission necessary when considering an issue such as this to avert to basic principles.

Death is fundamental to life. It follows that prima facie people should have control of how and when they die and to make this right reality they should be able to ask for assistance from medical practitioners.

This idea is to some extent reflected in the common-law which is that:

> An adult who... suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered.... The right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent. - *Re T* [1992] 4 All ER 649 at 652-3 (per Lord Donaldson MR)

In the well-known Philosophers Brief[1] a group of philosophers[2] argued that there is no logical difference between a position where health practitioners not only can but must follow the wishes of a patient who wishes no longer to be treated and that where they are asked to assist the patient to die.

[1] Dworkin, R. et al. 1997. "*Assisted Suicide: The Philosophers' Brief*". New York Review of Books 44 (27 March): 41–7.
[2] including TM Scanlon whose other work informs this submission

This is in fact the reasoning that underlines the decision of the Canadian Supreme Court in its decision on this topic.[3]

However, this argument has been criticized on the basis that there is a difference between killing and letting die. It is that a patient has the right to refuse treatment even when it is against her interests because the alternative would be forced treatment (which is unacceptable), but it is not true to say that a patient has the right to assistance to die even when it is against his interests.

The essential point is that in the first case a person is being forced to receive medical treatment against their will, which is morally unacceptable except perhaps in some very narrow circumstances relating to public safety. However to refuse to assist a person when it is not in their bests interests is not in all circumstances unacceptable.

In this submission we ask whether it is possible to construct a system of voluntary assisted dying which a well-informed person could not reasonably reject[4]. This does not deny a role for religious views in this or any other public issue:

> because it is reasonable—or at least not unreasonable—for a non-religious person to disagree with religious people over whether there is a God, and a fortiori over the particular form of religion in question, she can therefore reasonably disagree with them over the sanctity of life view which is derived from religious faith. In order for the sanctity of life view to be persuasive to all, it has to be grounded on terms that all could in principle accept, or on grounds of public reasons[5].

No doubt, a system which had no structures for ensuring so far as is practicable that the vulnerable were adequately protected, could reasonably be rejected. On the other hand, people suffering unbearable and unavoidable pain can reasonably reject a total ban on voluntary assisted dying.

We would ask if a rigorous system designed to prevent abuse of the right to assisted dying were effectively implemented could:

> A very "kind" or "considerate" patient who does not want to burden his family and who pretends to be entirely willing to choose PAS[6], reasonably reject the legalisation of PAS? I would think not, because her decision is, at least to some extent, voluntary, and hence she is responsible for her own opting for PAS[7]

In other words having regard to the unbearable pain and suffering of those with terminal or incurable illnesses a well-informed person could not reasonably reject VAD so long as it was only permitted in circumstances where all reasonable steps had been taken to protect the interests of the vulnerable.

Slippery Slope

One of the central claims of opponents of euthanasia is that allowing the practice will set in motion a process whereby inevitably the practice will be extended to cover unacceptable practices. However as the Royal Society of Canada put it[8]:

> The logic of slippery slope arguments, most charitably construed, is that there are certain risks that might accompany a policy, and that those risks are so grave, and/or society's capacity reliably to counteract them so limited, that it would be better not to enact the policy. This logic is however premised on a faulty assumption, namely that the status quo is itself without costs or risks, and that the only costs and risks to be factored into our deliberations concerning the desirability of moving away from the status quo are the ones that accompany the move away from the status quo. But this is never the case. Indeed, the problematic policy would not have been proposed had there not been a perception among policy-makers that the status quo was fraught with costs and harms.

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[3] *Carter v. Canada (Attorney General)* [2012] BCSC 886
[4] Brian Barry *Justice as Impartiality* OUP 1995 67-72
[5] Hon-Lam Li *What We Owe to Terminally Ill Patients: The Option of Physician-Assisted Suicide* (2016) 8 Asian Bioethics Review 224 at 231
[6] Physician Assisted Suicide
[7] Li supra at 240
[8] Royal Society of Canada *Expert Panel: End-of-Life Decision Making* (November 2011) page 68 (referred to as RSC)

Those who rely on the slippery slope argument ignore the fact that assisted dying is a reality today. However, at present it is conducted without regulation. Moreover, they ignore the suffering that many experience now which would be avoided or reduced by making assisted dying legal.

The available evidence supports the proposition that illegal medical practices are not more likely to occur after the legalisation of VAD.[9]

Nor is there any evidence in the Netherlands and in the State of Oregon of an actual slippery slope[10].

Furthermore many are concerned that VAD will impact particularly adversely on the poor. However the poor could equally be pressured to refuse treatment or ask for it be withdrawn, which would be a much worse way to die.

Palliative Care

A common argument in relation to voluntary assisted dying, is that it should not occur until a fully affective palliative care system is available. The concern is that voluntary assisted dying will be used before all palliative care options have been exhausted.

This fear has not materialised in overseas jurisdictions. In the Netherlands, 2/3 of requests for voluntary assisted dying have been reversed, often as a result of affective palliative care. Researchers found little evidence in Oregon to suggest that vulnerable people have been prescribed lethal medication rather than palliative care. To the contrary medical practitioners in Oregon have as a result of their assisted dying legislation become more astute to their patients' needs for palliative care.[11]

It is our submission, that the two MUST go hand-in-hand. At the same time as introducing voluntary assisted dying, the government needs to commit the funds necessary to provide a comprehensive and effective system of palliative care.

We will return to the issue of the interaction between voluntary assisted dying and palliative care later on in our submission.

Controls on access to voluntary assisted dying

QCCL would recommend that the following rules should govern access to voluntary assisted dying, which largely reflect those in the Netherlands[12],

1. It should be a criminal offence for any person or institution to pressure any patient to die.

2. The request should be an unprompted written request signed by 2 witnesses. Or if verbal properly documented

3. The person should be competent when the decision is made, this would cover advance health directives as well as contemporaneous requests

4. The request should be voluntary and informed

5. In our view the right to VAD should apply in 2 situations (a) a person must have an incurable disease, illness or medical condition that is advanced, progressive and will cause death within 6 months (12 months for neurodegenerative conditions) or (b) the patient's suffering was unbearable, with no prospect of improvement. We support VAD being available in both cases because there are many illnesses which render a person's life not worth living but whose condition is not terminal or not likely to be for some time, such as Guillain-Barre. There is in our submission no principled basis for excluding people facing long term suffering from VAD. However, we do recognise that this opens a broad range of conditions. For that

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[9] Willmott and White. *Future of Assisted dying reform in Australia* 42 Australian Health Review 616 at 618
[10] Hon-Lam Li supra at 235
[11] ibid page 237
[12] RSC page 77

reason, an additional control should be put in place, namely that a third medical opinion should be obtained from a psychiatrist before VAD can proceed in a case not involving a terminal illness.

6. A medical practitioner has informed the patient about his or her situation and his or her prospects

7. The medical practitioner has concluded, together with the patient, that there is no reasonable alternative in light of the patient's situation. This element, as opposed to one such as " suffering that cannot be relieved in a manner that the person considers tolerable" provides for a more objective assessment of the patient's situation by requiring both patient and medical practitioner to agree that it cannot be relieved. This requirement will ensure that palliative care is properly considered and administered.

8. The patient consulted at least one other independent medical practitioner who must have seen the patient and given a written opinion on the criteria referred to in 3-7 above

9. There should be a delay between the request being approved and implementation of 48 hours

10. As is the case under Dutch Law, medical practitioners who perform VAD can report the case to a committee consisting of a legal, medical and ethics expert. If the committee assesses they have complied with the requirements of the legislation they would be immune from prosecution in the absence of evidence of dishonesty by them in their report.

Children

In *X and Others v The Sydney Children's Hospitals Network*[13] the New South Wales Court of Appeal summarised the law on the rights of children to refuse medical treatment:

> The general principle of the common law is that non-consensual medical treatment involves an assault, thus constituting both a criminal offence and a tort. That "principle of personal inviolability", as noted in Secretary, Department of Health and Community Services v JWB (1992) 175 CLR 218 (Marion's Case) at 234, echoes the well-known words of Cardozo J in Schloendorff v Society of New York Hospital, 105 NE 92 (NY Ct App, 1914) at 93: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault. (at page 298)
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> In Gillick v West Norfolk and Wisbech Area Health Authority [1986] 1 AC 112....., Lord Scarman stated at 186: "The underlying principle of the law was exposed by Blackstone and can be seen to have been acknowledged in the case law. It is that parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision." 22 More specifically, in a passage adopted by the majority in the High Court in Marion's Case, Lord Scarman stated at 188–189: "In the light of the foregoing I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law. Until the child achieves the capacity to consent, the parental right to make the decision continues save only in exceptional circumstances." (at page 300)
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> As in the UK and Canada, no state court has gone so far as to suggest that the 'mature minor' doctrine effectively 'reclassifies' mature adolescents as adults for medical treatment purposes. ... ... [69] What is clear from the above survey of Canadian and international jurisprudence is that while courts have readily embraced the concept of granting adolescents a degree of autonomy that is reflective of their evolving maturity, they have generally not seen the 'mature minor' doctrine as dictating guaranteed outcomes, particularly where the consequences for the young person are catastrophic." Principle as well as authority is against acceptance of the applicants' proposed limitation on the scope of the court's jurisdiction. The very concept of a "mature minor" envisages a fact-finding exercise with respect to a specific young person. That exercise is itself, presumably, undertaken in the parens patriae jurisdiction. Accordingly, the applicants' submissions are best under-stood as imposing a limit on the power to grant

[13] (2013) 85 NSWLR 294

relief if a particular finding is made, rather than the imposition of a limitation on the jurisdiction of the court. (at page 305)

Contrary to the view of the Court in that case, it is our submission that the views of mature minors on medical questions, including on voluntary assisted dying, should be respected. We would define such a mature minor as a child over 12 years of age who, in the words of Lord Scarman, has a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.

However we do recognise that children are entitled to extra protection when making their decision.

Firstly before a child's request to die is authorised they should be assessed by an independent psychiatrist.

Secondly at least one of the independent medical practitioners should have specific qualifications and experience in dealing with children.

Thirdly, in the case of children a request for VAD should not be based solely on an underlying psychiatric condition.

Psychiatric Conditions

The question for discussion here is whether VAD should be permitted where the sole underlying medical condition is psychiatric.

The Council recognises that many individuals suffering from psychiatric conditions have the same capacity as those not suffering from such conditions. In the QCCL's view a distinction must be made between the person, no matter what the degree of their mental illness, who has a sufficient insight in order to make an informed decision as to whether or not to consent to medical treatment and those who do not have that capacity. In the Council's view a patient who has capacity to make an informed decision to consent to medical treatment cannot be the subject of involuntary treatment unless the patient presents an immediate and substantial danger to himself or herself or others or engages in dangerous or potentially destructive conduct.[14]

The same principle, subject to appropriate controls must apply to the case of requests by those with psychiatric conditions for VAD.

The particular issue here is many psychiatric conditions distort the perceptions of those suffering from them, so that many patients with personality disorders or major depression feel as a result of their psychiatric condition that they can never get any better[15].

To address the question of distorted perceptions, extra safeguards should apply where the underlying condition is psychiatric.

Firstly as is the case in Holland and Belgium a third medical opinion, from an independent psychiatrist should be required before VAD can proceed.

Further one of the advantages of requirement 7 above is that it addresses the distorted perception problem by requiring both two medical practitioners and the patient to agree on the issue of the likely effectiveness of treatment.

Medical practitioners

We use the term medical practitioners, rather than a doctors, because we note that in Canada, nurse practitioners are allowed to provide assistance in dying[16]. We would submit, that extending the right to provide assistance beyond physicians ought to be considered in Queensland, for the same reasons it has been allowed in Canada - overcoming the scarcity of physicians in remote and rural communities.

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[14] A test derived from US cases such as *Rivers v Katz* 495 NE (2d)337; *The People v Medina* 705 P (2d) 961; *Rogers v Commissioner Mental Health* 458 NE (2d) 308

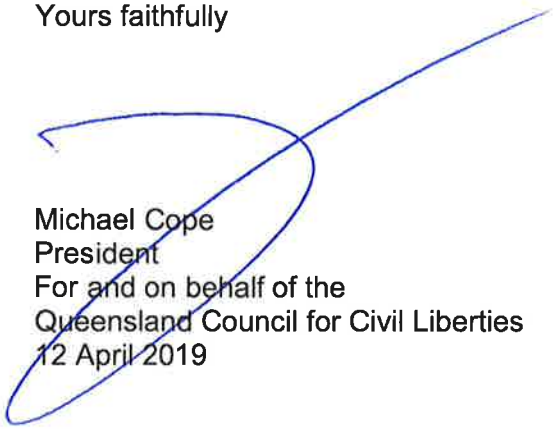
[15] Council of Canadian Academics 2018 *The State of Knowledge on Medical Assistance in Dying where a mental disorder is the sole underlying condition*

[16] *Medical Assistance in Dying: Lessons for Australia from Canada* 17 QUT Law Review 127 at 134

The other issue here is should medical practitioners be able to object to providing VAD. In our submission respect for their rights demands that medical practitioners should be able to refuse to assist. However, objecting medical practitioners ought to be required to transfer the patient to another practitioner who will provide the required services in a timely manner. The reason for this is that if only medical practitioners are permitted to provide assistance but they are not obligated to do so, then their rights are not limited but the rights of those seeking assistance could potentially be unfairly limited[17].

We trust this is of assistance to you in your deliberations.

Yours faithfully



Michael Cope
President
For and on behalf of the
Queensland Council for Civil Liberties
12 April 2019

[17] RSC page 62