VOLUNTARY ASSISTED DYING BILL 2021

Queensland Parliament

Dissenting Report

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VOLUNTARY ASSISTED DYING BILL 2021: DISSENTING REPORT

The *Voluntary Assisted Dying Bill 2021* was introduced into Parliament on 25 May 2021 by the Hon Annastacia Palaszczuk MP, Premier and Minister for Trade and referred to the Health and Environment Committee for detailed consideration.

This dissenting report considers the "*main purposes*" of the Bill, as set out in Clause 3 (the "*main purposes of this Act*"). It does so in the light of the detailed provisions of the Bill, the submissions and evidence presented to the Committee and the experience with similar legal schemes in other jurisdictions.

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WHY THIS DISSENTING REPORT?

This Bill, if passed, would introduce into Queensland practices that the World Medical Assembly (WMA), after extensive international consultation with the **115 national medical associations** which constitute it, reaffirmed as recently as October 2019, were **contrary to medical ethics** and should be firmly opposed.

> *The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide.*
>
> *For the purpose of this declaration, euthanasia is defined as a physician deliberately administering a lethal substance or carrying out an intervention to cause the death of a patient with decision-making capacity at the patient's own voluntary request. Physician-assisted suicide refers to cases in which, at the voluntary request of a patient with decision-making capacity, a physician deliberately enables a patient to end his or her own life by prescribing or providing medical substances with the intent to bring about death.*
>
> *No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end.*[1]

The Australian Medical Association likewise affirms that:

> *that doctors should not be involved in interventions that have as their primary intention the ending of a person's life.*[2]

End of Life medical experts – Palliative Care Queensland, the Queensland Directors Palliative Care Group (Submission 1158) and other palliative care specialists – point out that if palliative care was adequately funded, and there was equitable access for all Queenslanders regardless of where they live, then terminally ill Queenslanders would have an improved quality of life*,* "*through the prevention and relief of suffering*" including the "*treatment of pain and other problems whether they are physical, psychosocial, emotional or spiritual*":

> *Palliative care improves the quality of life of people while they are living with a life-limiting illness and their families as they collectively confront the issues and challenges associated with life-limiting illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems whether they are physical, psychosocial, emotional, or spiritual.* (Submission 1158 – Palliative Care Queensland).

Sadly, as an alternative to high standards and availability of palliative care that relieves suffering, the ending of life through the self-administration and practitioner administration of a poison in a sufficient dose to cause death is being promoted through the *Voluntary Assisted Dying Bill 2021* as a solution for those who may be suffering due to a terminal illness.

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[1] https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/

[2] https://www.ama.com.au/sites/default/files/documents/AMA_Position_Statement_on_Euthanasia_and_Physician_Assisted_Suicide_2016.pdf

In his evidence to the Committee, Dr Philip Nitshcke, who was the only medical practitioner to end the lives of patients under the Northern Territory's *Rights of the Terminally Ill Act 1995*, called for the adoption of a "*non-medical*" model that would facilitate access to a substance to be used to cause death for virtually anyone who wanted it, including those who are simply "*tired of life*.[3]

Once the euthanasia genie is out of the bottle it doesn't go back in.

The flow on affect from initial legalisation has proven to be **unstoppable and irreversible** once introduced. What is initially proposed as a measure to help a very small number of people, said to be in intolerable physical pain, is progressively broadened to apply to thousands of people, including those with no physical medical condition. Initial procedural safeguards are also relaxed. Once you **lift the lid on Pandora's box**, there's no going back.

Many vulnerable people experience subtle pressure to take their own life – some are made to feel almost duty bound to their family or to society to end their life prematurely. When **elder abuse is combined with legalised access to the administration of life-ending poisons**, it inevitably leaves the most vulnerable at risk of being **coerced into ending their lives by assistance to suicide or euthanasia**. This results in **wrongful deaths**, whereby people's lives are taken from them without their full cognisance or consent. Wrongful deaths have followed these laws everywhere they are introduced.

Most Queenslanders, when they understand that "voluntary assisted dying" is actually death by poison – either by lethal injection or swallowing a poison cocktail – don't support it. Of **the 5,672 submissions** received by the Committee a **majority of 3,217 (57%) were OPPOSED** to *the Voluntary Assisted Dying Bill 2021*, while **only 2,455 (43%)** were for it. To say that there was "strong support" for the Bill by way of the submissions and hearings is not a factual statement. Much evidence presented to the Committee of the failures, dangers and risks of euthanasia and assistance to suicide as experienced in other countries like Canada and the Netherlands - eg. mounting numbers of wrongful deaths, increase in suicide numbers – does not appear in the Committee's report.

Committee reports are adopted by vote of the committee. Where a vote is tied, the Parliament of Queensland Act provides that Chairs have a casting vote. I expect that Statements of Reservation and dissenting reports attached to the committee's report will provide readers with some indication as to how the committee voted. **This dissenting report recommends that the Bill NOT be passed.**

Many Queenslanders from diverse cultural and faith backgrounds –**first nation peoples, migrant and ethnic communities, multi-faith and majority Christian communities – oppose** euthanasia and assisted suicide. For many of them human life is sacred. For others it is contrary to good medical practice and the proper role of a medical practitioner to intentionally end a human life. These individuals and institutions shouldn't be forced to participate in the taking of human life against their medical judgment, conscience, or religious beliefs.

Individual medical and health care practitioners and medical facilities and aged-care centres should be able to **opt-out** from participating in a practice or providing a "service" that **goes against their strongly held convictions** – whether based on ethics, religion or their understanding of good medical practice. Individuals should not be "forced" to adopt a practice that takes a human life. Hospitals, like the Mater, should not be "forced" to operate against their clear convictions. Should these laws pass, as many as 1 in 4 hospital beds in Queensland would be put at risk of closure. This would be crippling to the Queensland Health System which is already considered a basket case.

[3] https://www.parliament.qld.gov.au/documents/committees/HEC/2021/VADB2021/trns-15Jul2021.pdf

The Committee process of the Bill was rushed from the beginning – with only 5 days of Stakeholder Hearings, only 2 of those days outside Brisbane. Members of the committee should have been provided with much more time to consider the committee's 236 page report. The time provided to consider the report was completely inadequate for a Bill of such complexity, controversy and magnitude. No doubt others will consider that matter further when time allows.

This dissenting report takes us **beyond the deeply felt and personal views** held in the community that naturally occur upon the sad loss of loved ones and asks people to consider all of the findings and facts that show this legislation is fatally flawed and will not achieve what its advocates, backers and promoters promise. The taking of a poison that deliberatively causes death, is not the best form of relief from suffering that is available. If the best we can hope to offer terminally ill Queenslanders suffering intolerable pain is a poison, instead of the highest standard of palliative care, we are in serious trouble as a society.

I invite all readers, especially MPs, to read this dissenting report to the end with an open mind, before deciding a final position on the *Voluntary Assisted Dying Bill 2021*.

OUTLINE OF FINDINGS

This Dissenting Report makes the following eight "Findings":

FINDING 1:
The Bill would make it legal for one person to take the life or help end the life of another person, or to counsel or help another person to take their life.

FINDING 2:
The Bill would increase the number of suicides in Queensland as opposed to reducing them.

FINDING 3:
The Bill fails to ensure that only eligible people will be able to access assisted suicide or euthanasia.

FINDING 4:
The Bill fails to ensure that patients are offered all options to manage their illness prior to the commencement of any life-ending procedure.

FINDING 5:
The Bill fails to adequately define "suffering" to limit it to intolerable physical pain.

FINDING 6:
The Bill provides inadequate protection to those affected by a mental illness.

FINDING 7:
The Bill fails to protect the vulnerable from coercion and undue influence.

FINDING 8:
The Bill fails to safeguard the vulnerable from a prolonged, complicated or painful death as a result of the administration of a poison prescribed under the Bill's provisions.

RECOMMENDATIONS

This Dissenting report makes five "Recommendations":

RECOMMENDATION 1: That the Voluntary Assisted Dying Bill 2021 NOT be passed.

RECOMMENDATION 2: If, notwithstanding Recommendation 1, the Bill is passed it ought to be amended to remove Clause 16 (4) and Clauses 84 and 85, and leave all health practitioners (and speech pathologists) in Queensland free to exercise good practice in accordance with internationally recognised medical ethics prohibiting actions intended to cause the death of a person or any referral directed to that end.

RECOMMENDATION 3: If, notwithstanding Recommendation 1, the Bill is passed then all such provisions in Division 2 of Part 6 of the Bill should be removed, apart from those in Clause 98.

RECOMMENDATION 4: If, notwithstanding Recommendation 1, the Bill is passed then the reference to revoking a request should be removed from Clause 141.

RECOMMENDATION 5: That Recommendations 2 and 3 of the Chair's Report be opposed.

"MEDICAL ASSISTANCE TO END THEIR LIVES": ESTABLISHING "A LAWFUL PROCESS"

The Bill if passed would establish a "*lawful process*" for people to "*end their lives*".

This "*lawful process*" would create exceptions to the current comprehensive prohibitions on murder and counselling and aiding suicide.

An exception to the law on murder

Section 302 (1) (a) of the *Criminal Code* defines murder to include acts where a person "*intends to cause the death of* [another] *person*".

The Bill creates an exception to this by making it lawful, under certain circumstances, for a medical practitioner, nurse practitioner or registered nurse to administer to a person a S4 or S8 poison "*of sufficient dose to cause death*" with the intention of causing that person's death.

As well as the exemption from the law on murder for the practitioner or nurse who administers the lethal dose of poison, other people, who would otherwise be liable to a charge of murder under Section 7 of the *Criminal Code*, would also be exempt, including:

- the "*coordinating practitioner*" who prescribes a poison "*of sufficient dose to cause death*" (Clause 53 (2)) and

- the "*authorised supplier*", a pharmacist, who supplies the poison (Clause 53 (4)).

An exception to the law on aiding suicide

Section 311 (b) of the *Criminal Code* comprehensively prohibits aiding a person "*to kill himself or herself".*

The Bill would create an exception to this prohibition **by authorising the following defined persons to lawfully aid a person to kill himself or herself**.

The "*coordinating practitioner*" who prescribes a poison "*of sufficient dose to cause death*" by self-administration of the poison by a person for the purpose of ending the person's life (Clause 52 (2)); the "*authorised supplier*", a pharmacist, who supplies the poison (Clause 52 (4)); the *contact person* or an *agent* of the person who receives the poison from the "authorised supplier" and supplies the poison to the person (Clause 52 (4)-(6)); any person who, at the request of the person who takes the poison with the intention of ending the person's life, prepares the poison and supplies the prepared poison to the person (Clauses 52 (7)).

The only qualification for a "*contact person*" is that the person be 18 years of age or older. There are no qualifications, including no age qualifications, for an agent of the person or a person who is requested to prepare the poison and supply it to the person to self-administer with the intention of ending their lives.

The Bill would explicitly authorise a person to ask any other person (**including a child**) to prepare a poison for the person to self-administer with the intention of ending the person's life.

An exception to the law on counselling suicide

Section 311 (c) of the *Criminal Code* comprehensively prohibits counselling a person "*to kill himself or herself*" and "*thereby induc[ing] the other person to do so*".

The Bill would create a broad exception to this prohibition.

Clause 8 of the Bill would provide that "*For the purposes of the law of the State … a person who dies as the result of the self-administration of a*" poison prescribed under this Act of a sufficient dose to cause death "*does not die by suicide*".

[Note: This Clause also provides that when a person dies from *administration* of such a poison the person "*does not die by suicide*". This is a nonsensical provision as under existing law the person would die by murder, not by suicide.]

By creating a **legal fiction** that a person who dies as a result of the self-administration of a poison prescribed under the Bill "does not die by suicide", it would become legal for:

- any person to counsel (suggest, encourage, persuade, recommend, urge) a person to take steps to end the person's life by self-administration of a poison, including requesting a prescription from a medical practitioner, filling a prescription and, once supplied, self-administering the poison for the purpose of causing the person's death;

  Clauses 141 and 142 create new offences for inducing a person to request or to self-administer a poison under the Bill but only if this is done "*dishonestly or by coercion*". However, the maximum penalty for these new offences is 7 years imprisonment – compared to liability for imprisonment for life.

- any health care worker – including a personal care worker - to "*suggest*" (counsel, encourage, persuade, urge) that a person takes steps to end the person's life by self-administration of a poison provided the person requests "*information*" (Clauses 7 (1) and (3))

  For example, a personal care worker for a person with a disability could, if the person says "I hear there is a new voluntary assisted dying law, what's that all about?" could then initiate a

discussion and actively suggest that the person ought to pursue ending the person's life using the Bill's provisions – "*Don't you think you would be better off dead?*"; and

- any medical practitioner or nurse practitioner – without any further qualifications whatsoever, any requirement to have undergone the approved training under Clause 165 of the Bill, or any requirement to document or report the discussion – to "***initiate discussion***" with a person and actively "*suggest*" (counsel, encourage, persuade, urge) that a person takes steps to end the person's life by self-administration of a poison provided the practitioner also "*informs the person about the treatment options available to the person and the likely outcomes of that treatment; and the palliative care and treatment options available to the person and the likely outcomes of that care and treatment*".

  This would allow any such practitioner who believes a person would be better off dead to **actively steer the person towards ending the person's life**. In many cases the practitioner will not have the requisite qualifications or experience to provide comprehensive and accurate information on treatment options and likely outcomes (this is usually the role of a specialist) nor on palliative care (also a specialised role).

The prohibition under s311 (b) of the Criminal Code against counselling suicide was the subject of comment by judges of the Queensland Court of Appeal in its 19 June 2020 decision in the case of *R v Morant [2020] QCA 135* in which Graham Morant's appeal against his conviction for aiding the suicide of his wife was rejected on all four grounds of appeal and the sentence of 10 years imprisonment was upheld as fair.

Morant was convicted on two counts under s311 of the Queensland Criminal Code. The first was that he had counselled Ms Morant to kill herself and thereby induced her to do so. The second was that he had aided her in killing herself.

One of the grounds of appeal was the belated discovery of two emails Ms Morant had exchanged with Dr Philip Nitschke. The emails presumably showed that she had suicidal ideation and was actively considering means of suicide.

However, these things were already apparent from evidence presented at Mr Morant's trial. As Sofronoff P concluded (at 38):

> *The evidence could not have helped the appellant. It would, instead, have reinforced Ms Morant's **vulnerability** to the appellant's inducements.*

Sofronoff P explains (at 47):

> *It was implicit in the jury's verdicts that the appellant had counselled Ms Morant to kill herself with the intention that she should commit suicide. It also follows that the jury found that the counselling was effective to induce her to commit suicide so that, but for the appellant's counselling, she would not have gassed herself on 30 November 2014.*

Morant stood to benefit from three life insurance policies to the total of $1.4 million.

His efforts to induce his wife to commit suicide included recounting to her a story about "*a customer of his [who] had taken out policies of insurance in favour of his wife and had then killed himself*." Mr Morant told his wife that that was "*an amazing and wonderful thing*" to have done. He encouraged her to do the same for him.

Sofronoff P concluded (at 64-65):

> *The present case is a paradigm case that exhibits **the** wickedness **of the offence of counselling and thereby inducing a victim to kill herself**. The offence was committed against **a woman who was vulnerable** to the appellant's inducements. His actions were premeditated, calculated and were done for financial gain… The offence was a serious one that involved a killing of a human being.*

Another of the judges, Boddice J summarised (at 248-249) the case against Graham Morant:

> *[T]he deceased was **a vulnerable person with difficulties with her physical health, who was already suffering depression**; and the fact that the appellant, by his conduct**, took advantage of those vulnerabilities in order to persuade her to kill herself** and then assisted her to do so.*
>
> *In addition to those matters, **the more serious aspect of the offences, counselling suicide, occurred over a period of months**. Its seriousness was aggravated by the fact that the appellant had also aided the deceased to kill herself, being the end result of that extended period of counselling.*

If the "lawful process" for persons to "*end their lives*" which it is a "*main purpose*" of this Bill to effect, had been in place in the months leading up to Ms Morant's death then Graham Morant could have avoided any liability by counselling his vulnerable wife to request, and then to subsequently self-administer, a lethal poison. Indeed, he could have prepared the lethal poison for her to take.

Moreover the prospect of a medical practitioner concluding that Mrs Morant was being coerced by her husband, and therefore not acting voluntarily and was ineligible, would be remote.

The current comprehensive prohibitions of murder and of aiding or counselling suicide protect every person in the community. The Bill limits those prohibitions by providing exceptions permitting acts that would otherwise be unlawful. It is one of the main purposes of the Bill to do so.

FINDING 1: The Bill <u>would establish a lawful process for a person to have the person's life ended</u> by a medical practitioner, nurse practitioner or registered nurse administering a lethal poison (by creating an exception to the law on murder) and a lawful process allowing other persons to counsel and aid a person to end the person's life by self-administration of a lethal poison (by creating broad exceptions to the prohibition on counselling and aiding suicide).

IMPACT ON SUICIDE PREVENTION

Queensland has a goal of reducing the suicide rate by 50% by 2026 through a comprehensive commitment to suicide prevention.

As stated in *Our Future State*[4]

Suicide has devastating impacts on families, friends and communities. Over the past decade, an average of more than 600 Queenslanders each year have died by suicide. Suicide is the leading cause of death for Australians between 15 and 44 years of age. As an example in 2015, the number of deaths by suicide (746) in Queensland was three times greater than the Queensland road toll (243).

[4] https://www.ourfuture.qld.gov.au/assets/custom/docs/gov-objectives.pdf

What do we want to achieve? Reduce the suicide rate by 50% by 2026.

Some of the proponents of the Bill claim that if passed it would **prevent** suicides by terminally ill Queenslanders by providing medical assistance – a prescription for self-administration or practitioner administration of a poison in a dose sufficient to cause death - for them to end their lives rather than using do-it-yourself measures. Clause 8 of the Bill would mean that these cases, including those of self-administration of a lethal dose of poison, **would not be counted as suicides**.

Such measures should lead to a decrease in the official number of suicides.

This claim can be tested by examining the evidence from Victoria.

In debate on the Victoria's *Voluntary Assisted Dying Bill 2017*, then Victorian Minister for Health and Human Services, the Hon Jill Hennessy, claimed that:

Evidence from the coroner indicated that one terminally ill Victorian was taking their life each week.[5]

If this claim was correct **a decrease of around 50 deaths by suicide each year** ought to have occurred once the Act came into operation on 19 June 2019.

According to the Coroners Court of Victoria there were 694 deaths by suicide in Victoria in 2017, which would have included the 50 or so deaths per year of people with a terminal illness referred to by the Minister.[6]

In 2020 – the first full calendar year in which the *Voluntary Assisted Dying Act 2017* was in operation – there were 698 suicides recorded. There is no evidence of the anticipated decrease of 50 suicide per year.

In that same year, 2020, a total of 144 people ended their lives by self-administration of a poison prescribed under the *Voluntary Assisted Dying Act 2017* – nearly 3 times the number of suicides by terminally ill people that the Act was supposed to prevent.

Putting aside the legal fiction of not considering these deaths as suicides, a total of 842 Victorians intentionally ended their lives at their own hands in 2020, with or without a permit from the State of Victoria. This is an increase of 21.2% from 2017.

Another 31 Victorians died in 2020 by practitioner administration of a poison prescribed under the *Voluntary Assisted Dying Act 2017*. While these were not acts of suicide, they were acts which were reportedly **carried out by a medical practitioner at the request of the person with the intention of causing that person's death**. If these deaths are included, then the total for 2020 would be 873 deaths of Victorians through acts intended by the person to cause the person's death - a 25.8% rise since 2017.

FINDING 2: If passed the Bill is likely to lead to an increase in the total number of Queenslanders who die by officially recorded suicides as well as by acts of self-administration or practitioner

[5] https://www.parliament.vic.gov.au/images/stories/daily-hansard/Assembly_2017/Assembly_Daily_Extract_Thursday_21_September_2017_from_Book_12.pdf

[6] https://www.coronerscourt.vic.gov.au/sites/default/files/2021-01/Coroners%20Court%20Monthly%20Suicide%20Data%20Report%20-%20December%202020.pdf

administration of a poison under the Bill's provisions with the intention of causing the person's death. The Bill would lead Queensland away from, and not towards, the goal of reducing the suicide rate by 50% by 2026.

"ACCESSED ONLY BY PERSONS WHO HAVE BEEN ASSESSED TO BE ELIGIBLE"

Another "*main purpose*" of the Bill is "*to establish safeguards to ensure"* the "*lawful process for people to "end their lives"* is *"accessed only by persons who have been assessed to be eligible*".

It is worth noting that the safeguards aim only at ensuring persons have been "*assessed to be eligible*" before they are assisted to "*end their lives*".

The scheme established by the Bill hinges on the two assessments carried out against all the eligibility criteria by:

- the coordinating practitioner ("*first assessment*" (Clause 19 (1)); and
- the consulting practitioner ("*consulting assessment*" (Clause 30 (1)).

Additionally, in the case of "*practitioner administration*" only, the "*administering practitioner*" must be satisfied, at the time of administering the prescribed poison to cause the death of the person, that the person has "*decision-making capacity*" and is "*acting voluntarily and without coercion*" (Clause 53 (6)).

The Queensland Civil and Administrative Tribunal (QCAT) may, in limited circumstances, review an assessment by a coordinating practitioner or by a consulting practitioner that a person meets the eligibility criteria related to decision-making capacity, acting voluntarily and without coercion, and residency. (Clause 99)

In the case of positive assessment that a person has decision-making capacity and is acting voluntarily and without coercion it is unclear how such a matter would come before QCAT as it would first require that a third party – neither the medical practitioner, the person or the person who may be exercising the coercion – know that such a positive assessment has been made, be aware of the possibility of an application to QCAT and be accepted by QCAT as a "*person who has a sufficient and genuine interest in the rights and interests of*" the person who is the subject of the assessment.

QCAT cannot review assessments related to the other criteria nor can it review an administering practitioner's decision that he or she is "*satisfied*" of certain matters.

It is important to note that the Voluntary Assisted Dying Review Board's role relevant to ensuring access only to eligible persons is limited to verifying that the coordinating practitioner and consulting practitioner **have completed forms** indicating that they have carried out the assessments and found the person to meet the eligibility criteria; and where applicable, the administering practitioner has completed a form indicating that he or she is satisfied on the relevant matters.

There is no mechanism under the Bill for verifying the accuracy, reliability or honesty of the assessments.

It is within this overarching perspective on how the "safeguards" operate that this report now considers the five core eligibility criteria set it in Clause 10 (1) (a) – (c) of the Bill.

"A DISEASE, ILLNESS OR MEDICAL CONDITION THAT IS ADVANCED, PROGRESSIVE AND WILL CAUSE DEATH IS EXPECTED TO CAUSE DEATH WITHIN 12 MONTHS": DIAGNOSIS AND PROGNOSIS

Diagnosis is the process of determining what "*disease, illness or medical condition*" a person has. It can be a challenging process and is subject to errors even by experienced specialists.

Prognosis is the process of determining the likely outcome or course of a disease, including the likelihood of death and the possible timeframe in which death may occur. It is always just a rough estimate or best guess based on a range of factors.

Clause 10 (1) (a) requires that a person "*has been diagnosed with a disease, illness or medical condition that is advanced, progressive and will cause death*" and clauses 19 (1) and 30 (1) assign to the coordinating practitioner and the consulting practitioner the duty of assessing whether a person meets this criterion.

Neither "*advanced*" nor "*progressive*" are defined in the Bill and have no precise medical definition. The phrase "*will cause death*" appears to require that a condition be definitively terminal although this expectation may be modified by the additional criterion that the condition be "*expected to cause death within 12 months*".

The lack of any requirement for either the coordinating practitioner or the consulting practitioner to have any qualifications or experience relevant to the treatment and care of a person with the specific "*disease, illness or medical condition*" that he or she assesses the person as having been diagnosed with, makes it inevitable that there will be **some errors** made in the accuracy of the diagnosis and, even more so, in the accuracy of the prognosis.

The legal fiction (or **mandated falsification**) required by Clause 81 of the "*cause of death certificate*" to state that "*the cause of death of the person was the disease, illness or medical condition mentioned in section 10(1)(a) from which the person suffered*" and the preclusion, by Clause 171, of deaths caused by the self-administration or practitioner administration under the provisions of the Bill of a poison of a sufficient dose to cause death from being "*reportable*" to the Coroner, would have the effect of making it virtually impossible to determine posthumously that an error in diagnosis was made.

And it will, in every case, be impossible after a person dies by self-administration.

There is, however, evidence of errors in diagnosis and prognosis from other jurisdictions that allow self-administration of a prescribed lethal poison.

For example, after the family of retired Italian magistrate Pietro D'Amico, aged 62, insisted on an autopsy that he was found not to have a terminal illness at all, despite being given such a diagnosis by both Italian and Swiss doctors prior to undergoing assisted suicide in Switzerland.[7]

In Oregon, in 2018 one person ingested lethal medication 807 days (2 years 2 ½ months) after the initial request for the lethal prescription was made. The longest duration between initial request and

[7] https://www.thelocal.ch/20130711/assisted-suicide-in-question-after-botched-diagnosis

ingestion recorded is 1009 days (that is 2 years and 9 months).[8] Evidently in these cases the prognosis of only six months to live was inaccurate/

The example of Jeanette Hall, who is still alive today after commencing the process of seeking assisted suicide in Oregon in 2000, illustrates the danger of making assisted suicide available to people when first diagnosed with a terminal illness. Thankfully for Jeanette her doctor refused to collaborate in assisting her suicide and helped her find hope – and effective treatment – instead.[9]

Clauses 21 (1) (a) and 32 (1) (a) do allow for a coordinating practitioner or consulting practitioner who is "*unable to determine whether or not*" a person "*has a disease, illness or medical condition that meets the requirements of section 10(1)(a)*" to "refer the person to a registered health practitioner who has appropriate skills and training to determine the matter" and they "*may*" adopt the "*determination of the referee*".

This provision depends entirely on the coordinating or consulting practitioner recognising and acting on a self-assessment of his or her inability to determine these matters, and then on his or her decision to adopt or ignore the determination by the referee.

There is no explicit requirement in the Bill for the coordinating or consulting practitioner to inform the Voluntary Assisted Dying Review Board that in making an assessment they sought but then chose to ignore a determination by a referee.

FINDING 3: The Bill fails to meet one of its "main purposes", namely "*to establish safeguards to ensure"* the "*lawful process for people to "end their lives"* is *"accessed only by persons who have been assessed to be eligible*" because it provides for determinations of diagnosis and prognosis to be made by medical practitioners who may lack the requisite qualifications and the relevant experience to make such determinations accurately.

"THE TREATMENT OPTIONS AVAILABLE TO THE PERSON AND THE LIKELY OUTCOMES OF THAT TREATMENT"

Clause 22 (1) sets out a list of matters that the coordinating practitioner must inform a person about **after** he or she is satisfied that the person is eligible, including "*the treatment options available to the person and the likely outcomes of that treatment*" (Clause 22 (1) (b)).

Given the coordinating practitioner is not required to have any specialist qualifications or experience relevant to the particular "*disease, illness or medical condition*" nor may he or she ever have met the person before carrying out the first assessment, there is no guarantee that the information given to the person will be comprehensive and accurate. Advances in treatment options for many medical conditions occur all the time and a non-specialist medical practitioner cannot be expected to be fully informed about these developments. That is one of the reasons in normal medical practice for referring patients to a relevant specialist for diagnosis, prognosis, information on treatment options and treatment.

[8] Oregon Public Health Division, *Oregon Death With Dignity Act: 2018 Data Summary, Table 1,* p.13 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

[9] https://www.dailysignal.com/2015/05/18/assisted-suicide-how-one-woman-chose-to-die-then-survived/

Under the Bill's provisions it is inevitable that some people will proceed through the process and end their lives through self-administration or practitioner administration of a poison in sufficient dose to cause the person's death, when there was an available, effective treatment that the person was never offered.

FINDING 4: The Bill fails to ensure that before a person's life is ended by self-administration or practitioner administration of a poison intended to cause the death of the person, the person is offered all effective, available treatment for the person's disease, illness or medical condition.

"SUFFERING THAT THE PERSON CONSIDERS TO BE INTOLERABLE": PALLIATIVE CARE

Clause 10 (1) (a) (iii) of the Bill would provide that to be eligible a person must be "*diagnosed with a disease, illness or medical condition that … is causing suffering that the person considers to be intolerable*". Clauses 19 (1) and 30 (1) assign to the coordinating practitioner and the consulting practitioner the duty of assessing whether a person meets this criterion.

Clause 10 (2) provides that the "***suffering***, *caused by a disease, illness or medical condition, includes physical or mental suffering; and suffering caused by treatment provided for the disease, illness or medical condition*."

The inclusion of "*mental suffering*" and the phrase "*that the person considers intolerable*" expand eligibility well beyond cases where there is actual physical suffering that cannot be relieved.

From jurisdictions where some data on the reasons for which a person requests the prescription of a poison for self-administration (Oregon and Victoria) or physician administration (Victoria and Canada) in order to cause the person's death it is apparent that:

- few cases relate to actual physical suffering; and
- most cases relate to existential issues such as feeling like a burden, a loss of autonomy or an inability to participate in enjoyable activities.

The Voluntary Assisted Dying Review Board's Report on Operations January-June 2020[10] states that in Victoria "*Loss of autonomy was frequently cited by applicants as a reason for"* requests, with other commonly reported reasons including "*being less able to engage in activities that make life enjoyable, losing control of body functions, and loss of dignity*". Notably physical pain was not mentioned in this report.

The Oregon annual reports indicate that physical suffering is not a major issue for those requesting prescription of a lethal dose of poison.

Of the 1905 people who had died from ingesting a lethal dose of poison between 1998 and 2020 just over one in four (27.4%) mentioned "*inadequate pain control or concern about it"* as a consideration.[11]

[10] https://www.bettersafercare.vic.gov.au/sites/default/files/2020-08/VADRB_Report%20of%20operations%20August%202020%20FINAL_0.pdf

[11] Oregon Public Health Division, *Oregon Death With Dignity Act: 2020 Data Summary, Table 1,* p.11, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

Earlier annual reports noted that "*Patients discussing concern about inadequate pain control with their physicians were not necessarily experiencing pain."*[12]

However, in 2019 nearly 6 out of 10 (59.2%) of those who died after taking prescribed lethal medication cited concerns about being a "*Burden on family, friends/caregivers*" as a reason for the request.[13]

More needs to be done to address these existential concerns rather than resorting to measures to cause a person's death as an appropriate means of responding to concerns such as loss of autonomy and feeling a burden on others.

In his evidence to the Committee, Dr Philip Nitschke, who provided euthanasia to four people in the Northern Territory in 1995-96 under the Rights of the Terminally Ill Act, explained that a law facilitating direct ending of life for the "*extremely sick*" was only ever a first step and that any consistent approach required provision of assistance to those who, for whatever reason were simply "*tired of life*".[14]

The Bill's approach to "*suffering*" already points in this direction.

Clause 22 (1) sets out a list of matters that the coordinating practitioner must inform a person about **after** he or she is satisfied that the person is eligible, including "*the palliative care and treatment options available to the person and the likely outcomes of that care and treatment*" (Clause 22 (1) (c)).

Given the coordinating practitioner is not required to have any specialist qualifications or experience in palliative care and treatment, there is no guarantee that the information given to the person will be comprehensive and accurate. Advances in palliative care and treatment options occur all the time and a medical practitioner who has no specialist qualifications or experience in palliative care cannot be expected to be fully informed about these developments.

Clause 5 (e) of the Bill states as one of the "*principles that underpin this Act*" that "*access to voluntary assisted dying and other end of life choices should be available regardless of where a person lives in Queensland*". However, there is no equivalent guarantee that access to gold standard palliative care and treatment will be available regardless of where a person lives in Queensland.

Palliative Care Queensland in Submission 1158 pointed to a $247 million per year shortfall in adequate funding for palliative care in Queensland. The submission stated:

> *In Queensland, a person's choice to explore voluntary assisted dying should never be based on a lack of access to palliative care – however we fear that limited funding and access, as well as equity issues, could make this the case.*

Submission 111[15] from the Queensland Directors Palliative Care Group indicates that funded positions for specialists in palliative medicine falls well short of the benchmark set by Palliative Care Australia

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[12] Oregon Health Authority, *Sixth Annual report on Oregon's Death With Dignity Act,* 2004, p. 24 http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year6.pdf

[13] Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1,* p.12, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf

[14] https://www.parliament.qld.gov.au/documents/committees/HEC/2021/VADB2021/trns-15Jul2021.pdf

[15] https://www.parliament.qld.gov.au/documents/committees/HEC/2021/VADB2021/submissions/111.pdf

in 2018 of 2.0 FTE per 100,000 population. To meet the benchmark – aimed at ensuring adequate access to palliative care for all who need it – there ought to be 100.22 FTE funded positions for specialists in palliative medicine in Queensland but in 2021 there are only 43.40 – a shortfall of 56.82.

The Bill is premised on Queenslanders only choosing to end their lives by self-administration or practitioner administration of a poison when suffering cannot be relieved. While a significant shortfall in funded positions for specialists in palliative medicine exists unnecessary suffering will continue.

It will be inevitable if the Bill becomes law that some people will end their lives by self-administration or practitioner administration of a poison in sufficient dose to cause the person's death when the person's physical and mental suffering, including the person's existential concerns, could have been relieved through appropriate palliative care and treatment.

FINDING 5: The Bill fails to meet one of its "main purposes", namely "*to establish safeguards to ensure"* the "*lawful process for people to "end their lives"* is *"accessed only by persons who have been assessed to be eligible*" because it provides for determinations that a person has "*suffering that the person considers intolerable*" by medical practitioners who may lack the requisite qualifications and the relevant experience in palliative care and treatment that would enable them to relieve the person's suffering.

"THE PERSON HAS DECISION-MAKING CAPACITY"

Clause 10 (1) (b) of the Bill includes in the eligibility criteria that "*the person has decision-making capacity*".

Clause 11 (2) provides that "*A person is presumed to have decision-making capacity … unless there is evidence to the contrary*."

Clause 21 (1) (b) and (2) and Clause 32 (1) (b) and (2) provide that if a coordinating practitioner or consulting practitioner considers that he or she is "*unable to determine*" if the person "*has decision-making capacity*" then he or she must refer the person to "a registered health practitioner who has appropriate skills and training to determine the matter" and **may** adopt the determination of the referee.

Evidence from Victoria and Oregon suggests that where optional referral for assessing decision-making capacity is part of the scheme it is seldom used by assessing practitioners, who seem to be reluctant to conclude that they are unable to make a determination of decision-making capacity without assistance from another practitioner with the appropriate skills.

In Victoria, the Report on Operations July-December 2020[16] states that 17 people (3% of 562 applicants) had been referred for a specialist opinion on their decision-making capacity. There is no information available on the outcome of the referral.

[16] https://www.bettersafercare.vic.gov.au/sites/default/files/2021-02/VADRB_Report%20of%20operations%20Feb%2021_FINAL.pdf

In Oregon in 2019 only one person out of 191 people (0.52%) who died under the Oregon law was referred by the prescribing doctor for a psychiatric evaluation before writing a script for a lethal substance.[17]

A study in Oregon found that one in six applicants who died under Oregon's law had clinical depression.[18] Over the 23 years of Oregon's law it is likely that around 250 people with clinical depression were prescribed and took a lethal poison without being referred for a psychiatric evaluation.

Clause 13 (1) (a) of the Bill provides that people with a mental illness as defined in *Mental Health Act 2016*, section 10 – which would include clinical depression and other conditions such as bipolar disorder which profoundly affect decision-making capacity – are eligible under the Bill to request and be prescribed for self-administration or practitioner administration a poison in sufficient dose to cause the person's death.

Given the likely low rate of referral to an expert based on evidence from other jurisdictions with optional referral, it is inevitable that some people will die under the provisions of this Bill who had impaired decision-making capacity, including impairment due to treatable clinical depression or another mental illness, but who are wrongly assessed as eligible.

In the case of self-administration there is no provision for any further assessment of decision-making capacity once the prescription is written and filled. At the time it is "self-administered", which may be weeks, months or even years later, the person may have lost decision-making capacity and lack full awareness or understanding of the nature of the poison and its intended effect.

In the case of practitioner administration, the administering practitioner, who may be a registered nurse, is required by Clause 53 (6) (a) to assess the person "*at the time of administration*" as "*having decision-making capacity*". There is no option at this point for a referral to an expert and the presumption, in Clause 11 (2), in favour of a person having decision-making capacity still applies.

It is inevitable that in some cases a registered nurse, legally required to presume in favour of the person having decision-making capacity, will in the absence of any obvious evidence to the contrary, assess a person as having decision-making capacity when the person lacks it.

FINDING 6: The Bill fails to meet one of its "main purposes", namely "*to establish safeguards to ensure"* the "*lawful process for people to "end their lives"* is *"accessed only by persons who have been assessed to be eligible*" because it provisions relating to determining whether a person has "*decision-making capacity*" are insufficient to guarantee that no person lacking decision-making capacity is wrongly assessed as eligible, including persons with treatable mental illnesses such as clinical depression.

"THE PERSON IS ACTING VOLUNTARILY AND WITHOUT COERCION"; "PROTECT VULNERABLE PERSONS FROM COERCION AND EXPLOITATION"

[17] Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1,* p.11, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf

[18] Linda Ganzini et al., "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey", *BMJ* 2008;337:a1682, http://www.bmj.com/content/bmj/337/bmj.a1682.full.pdf

Another main purpose of the Bill is to "*protect vulnerable persons from coercion and exploitation*" (Clause 3 (c) (ii)).

Clause 10 (1) (c) of the Bill includes in the eligibility criteria that "*the person is acting voluntarily and without coercion*".

Clause 21 (3) and Clause 32 (3) provide that if a coordinating practitioner or consulting practitioner considers that he or she is "*unable to determine*" if the person "*is acting voluntarily and without coercion*" then he or she must refer the person to "another person who has appropriate skills and training to determine the matter" and **may** adopt the determination of the referee.

As well as the evidence cited above from Oregon, evidence from Canada and from Washington State confirm that feeling a burden on family is a reason for requests to have a person to be prescribed a lethal dose of poison to self-administer or have administered in order to end the person's life.

The 2020 annual report from Canada states that 35.9% of people reported as a reason for their request to end their lives feeling that they were a "burden on family, friends or caregivers". [19]

The data from Washington State[20] shows that in 2017 more than half (56%) of those who died from prescribed lethal drugs cited concerns about being a "*Burden on family, friends/caregivers*" as a reason for the request.

The obvious question to ask is whether this concern may be influenced by comments or behaviour from family, "friends" and caregivers - including health care practitioners - who find the person to be a burden or a nuisance or just taking too long to die.

Motives for family members to communicate such a message could include "inheritance impatience" or other selfish factors. Not all families are happy families.

The provisions of the Bill **are manifestly insufficient to lead to the identification of every case** where a person is not "*acting voluntarily and without coercion".*

Clauses 20 and 31 of the Bill require the assessing practitioners to undergo "*approved training*" and section 165 (2) (c) would provide that this includes "identifying and assessing risk factors for abuse or coercion".

The corresponding approved online training for medical practitioners in Victoria contains a total of **just over 5 minutes** (a 2 minute 20 second video and slides which take a further 2 minutes 50 seconds to read) on assessing voluntariness, including assessing the absence of coercion.

Claims that any practitioner who undergoes the "*approved training*" under the Bill will become capable of always identifying a lack of voluntariness or the presence of coercion are naïve and irresponsible.

In the case of self-administration there is no further assessment of whether a person is "*acting voluntarily and without coercion"* once poison of a sufficient dose to cause the death of the person is prescribed. Nor is a witness required to be present.

[19] https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/annual-report-2020/annual-report-2020-eng.pdf

[20] https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf

At the time of "*self-administration*" the person may be subject to coercion – overt or subtle – to take the poison. The poison may be administered surreptitiously, or the person may even be physically forced to take the poison. We will never know.

In the case of practitioner administration, the administering practitioner – who may have never met the person before and who may be a registered nurse – is required to determine at the time of administering the prescribed poison in a does sufficient to cause the death of the person that the person is "acting voluntarily and without coercion" (Clause 53 (6) (b)).

Clause 54 (2) (a) requires that a witness – who may be a person aged 18 years or more – is required to certify that "*the person appeared to be acting voluntarily and without coercion*".

There is nothing in the Bill to prevent this witness being the very person who, for selfish motives, is coercing the person to proceed with the administration of the poison.

FINDING 7: The Bill fails to meet another of its "main purposes", namely to "*protect vulnerable persons from coercion and exploitation*" because it provisions relating to determining whether a person is "*acting voluntarily and without coercion*" are insufficient to guarantee that no person subject to coercion is assisted to end the person's life.

RISKS OF SELF-ADMINISTERING OR BEING ADMINISTERED A POISON OF SUFFICIENT DOSE TO CAUSE A PERSON'S DEATH

Proponents of the Bill often appear to believe that any death brought about under the Bills provisions would be both rapid and peaceful. However, the Bill itself hints that this may not be the case.

Clauses 22, 65 and 70 all include provisions requiring a person to be given information about one or more of the following matters:

- the potential risks of self-administering or being administered a … substance likely to be prescribed under this Act for the purposes of causing the person's death;
- that the **expected** outcome of self-administering or being administered [such a] substance is death;
- the expected effects of self-administration of the substance;
- the period within which the person is likely to die after self-administration of the substance;
- the potential risks of self-administration of the substance;
- the expected effects of administration of the substance; and
- the period within which the person is likely to die after administration of the substance.

Period of time between administration of the poison and death

The Oregon Revised Statute at 127.897[21] requires a person, before being prescribed a lethal dose of poison under Oregon's law, to certify that "*I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility*."

Data from Oregon's annual reports shows the time from ingestion to death has been as long as 104 hours (4 days and 8 hours) in a person who ingested pentobarbital, the substance used in Victoria for self-administration. In 2019 one person took nearly two days (47 hours) to die after using a combination of substances known as DDMP2 and another person took 19 hours to die after using DDMA.[22] In 2020 one person took 8 hours to die after using DDMA, and another two people took more than 6 hours to die.[23]

Of 978 deaths between 2001-2020 for which data on the duration between ingestion and death is available 74 (7.6%) took more than 6 hours to die.

Other risks

The longest time to loss of consciousness has been four hours.

There are reported complications each year, with an overall failure rate of 0.42% (8 people recovered consciousness out of 1905) and an overall complication rate of 6.3% (52 out of 827 people for whom this data is available).

In 2020 there were five cases of complications out of 72 – 6.94% of those for whom information about the circumstances of their deaths is available. This included one case of seizures and 3 cases of difficulty ingesting or regurgitating the poison.[24] In 2019 nearly one in ten (9.84%). In 2018 nearly one in eight (12.12%) had complications and additionally, one person failed to die and regained consciousness.[25] Two people had seizures in 2017.[26]

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[21] https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ors.aspx

[22] Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1,* p.13, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf

[23] https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

[24] Oregon Public Health Division, *Oregon Death With Dignity Act: 2020 Data Summary, Table 1,*p.12 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

[25] Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1,* p.12 , https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

[26] Oregon Public Health Division, *Oregon Death With Dignity Act: Data Summary 2017, Table 1. Characteristics and end-of-life care of 1,275 DWDA patients who have died from ingesting a lethal dose of medication as of January 19, 2018, by year, Oregon, 1998-2017,* p.10, http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf

As a recent article in the journal *Anaesthesia* found:

Complications related to assisted dying methods were found to include difficulty in swallowing the prescribed dose (≤9%), a relatively high incidence of vomiting (≤10%), prolongation of death (by as much as seven days in ≤4%), and failure to induce coma, where patients re-awoke and even sat up (≤1.3%). ***This raises a concern that some deaths may be inhumane.***[27]

FINDING 8: The provisions under the Bill may lead to slow, inhumane deaths from the self-administration or administration of a poison in sufficient dose to cause the death of a person.

NOT FIT FOR PURPOSE AND NOT SAFE

In the light of this detailed consideration of the Bill in the light of its main purposes as set out in Clause 3 of the Bill and the eight findings set out above, it is the conclusion of this dissenting report that the Bill is not fit for purpose, that it would fail to ensure that access to the prescription for self-administration or administration of a poison in sufficient dose to cause the death of the person was limited to eligible persons; would fail to protect vulnerable people from coercion and exploitation and would fail to ensure a rapid, peaceful, humane death in every case.

Although amendments could be envisioned that **may reduce** some of the weaknesses in the Bill, there is no evidence from any jurisdiction in the world that a legal regime can be designed that could exclude medical errors and a failure to identify lack of decision-making capacity, voluntariness or freedom form coercion and exploitation.

Accordingly, Recommendation 1 of the Chair's Report, that "*the Voluntary Assisted Dying Bill 2021 be passed*" is OPPOSED and the following alternative recommendation made:

RECOMMENDATION 1: That the Voluntary Assisted Dying Bill 2021 not be passed.

"TO PROVIDE LEGAL PROTECTION FOR HEALTH PRACTITIONERS WHO CHOOSE NOT TO ASSIST PERSONS TO EXERCISE THE OPTION OF ENDING THEIR LIVES IN ACCORDANCE WITH THIS ACT"

There are a variety of reasons why a health practitioner may want to choose not to assist a person to access a poison for the purpose of ending the person's life.

Some may have an in-principle ethical objection – whether based on a religious belief or otherwise – to any act intended to cause the death of a person, even at the request of the person.

After all, that is the principle to which the current law against murder gives effect. It is a principle which has been a core foundation of ethics and law across civilisations for millennia.

Health practitioners may also uphold the Hippocratic tradition which is expressed in the position of the World Medical Assembly, which it reaffirmed after extensive international consultation as recently as October 2019:

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27 https://assets.nationbuilder.com/australiancarealliance/pages/139/attachments/original/1551911256/Sinmyee_et_al-2019-Anaesthesia.pdf?1551911256

The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide.

For the purpose of this declaration, euthanasia is defined as a physician deliberately administering a lethal substance or carrying out an intervention to cause the death of a patient with decision-making capacity at the patient's own voluntary request. Physician-assisted suicide refers to cases in which, at the voluntary request of a patient with decision-making capacity, a physician deliberately enables a patient to end his or her own life by prescribing or providing medical substances with the intent to bring about death.

No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end.[28]

Clause 16 (4) of the Bill would, while not requiring a formal referral, nonetheless require a medical practitioner in every case where he or she for whatever reason refused a "first request" for access to a prescribed poison to be self-administered or practitioner administered in order to cause the death of the person, give the person information that would facilitate such access.

This provision would inappropriately force a medical practitioner to choose between medical ethics – as affirmed by the WMA – and a Queensland statute.

Consider a psychiatrist treating a person with a serious mental illness that includes suicidal ideation. If the person has a possible diagnosis of a condition that is expected to cause death in 12 months and makes a first request to the psychiatrist, the psychiatrist would be legally required to facilitate the person's pursuit of ending his or her life through self-administration or practitioner administration of a poison.

It is an unconscionable, unjustifiable provision and should be removed.

RECOMMENDATION 2: If, notwithstanding Recommendation 1, the Bill is passed it ought to be amended to remove Clause 16 (4) and Clauses 84 and 85, and leave all health practitioners (and speech pathologists) in Queensland free to exercise good practice in accordance with internationally recognised medical ethics prohibiting actions intended to cause the death of a person or any referral directed to that end.

INSTITUTIONS PROVIDING CARE

Similarly, the Bill would impose on entities such as residential aged care facilities and hospitals – including those formed and operated by free associations of people sharing an ethical approach that excludes facilitating any acts intended to cause the death of a person – requirements to actively facilitate or at least to allow on their premises such acts.

It is particularly egregious to empower a coordinating practitioner to be the deciding practitioner in relation to whether actions under the Bill, including the administration of a poison in a sufficient dose to cause the death of a person, will take place on the premises of a facility which is operated by a free association of persons who are opposed to any such acts under any circumstances.

Submission 260 from AMA Queensland proposed this change:

[28] https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/

We recommend this section of the Bill be changed to include organisational conscientious objection as we believe that some health care facilities which provide care may have a distinctive mission or ethos which should permit it to refuse to provide particular services due to an 'institutional conscientious objection'. In that situation, the institution should inform the public of this so that patients can seek care elsewhere.

RECOMMENDATION 3: If, notwithstanding Recommendation 1, the Bill is passed then all such provisions in Division 2 of Part 6 of the Bill should be removed, apart from those in Clause 98.

PREVENTING SUICIDE SHOULD NOT BE AN OFFENCE

Clause 141 of the Bill would, for the first time in Queensland, make it an offence to try to persuade a person not to end the person's life.

While the offence of inducing a person to revoke a request for "*access to voluntary assisted dying*" formally only applies where the person acts "*dishonestly or by coercion*", it may nonetheless deter some people from earnestly pleading with a loved one or family member not to take this irrevocable step.

"*Please Mum don't end your life now. We will look after you*," could be seen as a potential crime. A family member intent – perhaps for selfish reasons such as inheritance impatience - on Mum ending her life as soon as possible – may potentially threaten other concerned family members who want to talk Mum out of requesting or self-administering a poison to cause her death.

While coercing someone to end their lives could be done for a range of selfish motives, this does not apply to pleading strongly with a loved one not to end their lives.

RECOMMENDATION 4: If, notwithstanding Recommendation 1, the Bill is passed then the reference to revoking a request should be removed from Clause 141.

COUNSELLING, INCITING AND INSTRUCTING IN SUICIDE USING A CARRIAGE SERVICE

Under the *Constitution of Australia*, the Commonwealth Parliament has the "*power to make laws for the peace, order, and good government of the Commonwealth with respect to … postal, telegraphic, telephonic, and other like services*" (Section 51 (v)). These services are collectively referred to as "*carriage services*".

Section 109 of the Constitution provides that "*When a law of a State is inconsistent with a law of the Commonwealth, the latter shall prevail, and the former shall, to the extent of the inconsistency, be invalid*."

In 2005, the Commonwealth Parliament acted wisely in passing the *Criminal Code Amendment (Suicide Related Material Offences) Act 2005.* This Act introduced prohibitions, with appropriate penalties, into the Commonwealth Criminal Code, on the use of a carriage service to access, transmit or distribute "*suicide related material*", defined to cover material that counselled or induced suicide or instructed in a method of suicide.

The Chair's Report, in its Recommendation 2 proposes that "*the Commonwealth Government amend the Criminal Code Act 1995 (Cth) by inserting a definition declaring that "suicide" does not include voluntary assisted dying carried out lawfully pursuant to a law of a State or Territory*."

Its Recommendation 3 proposes "*that as a matter of urgency the Commonwealth Director of Public Prosecutions issue prosecutorial charging guidelines indicating that the offences in sections 474.29A and 474.29B of the Criminal Code Act 1995 (Cth) will not be prosecuted where a doctor or other person is acting in accordance with the procedure outlined in State voluntary assisted dying laws*".

Finding 1 (above) states in part that the Bill, if passed, would establish "**a lawful process allowing other persons to counsel and aid a person to end the person's life by self-administration of a lethal poison (by creating broad exceptions to the prohibition on counselling and aiding suicide)".**
Finding 2 (above) states in part that the Bill, if passed, "**would lead Queensland away from, and not towards, the goal of reducing the suicide rate by 50% by 2026".**

It is good public policy to prevent suicides. The Commonwealth Parliament has acted wisely, and in accordance with its constitutional responsibility for laws in relation to carriage services, by seeking to prevent the facilitation of suicides by that means. I note that in August, 2021 both the Prime Minister and Federal Leader of the Opposition have indicated they have no plans to weaken these Federal protections.

RECOMMENDATION 5: That Recommendations 2 and 3 of the Chair's Report be opposed.

Finally, I would like to thank the Parliamentary Secretariat/Staff of the HEC Committee for their hard work and assistance in the scrutiny of this Bill. They were put under unusual time-pressure by the haste to push the Bill through. Any criticisms of content of the Committee Report and of the process of the Committee should not be seen as a reflection on them, their hard work and dedication. I thank them.

Again, I call on all MPs to reject this Bill.

Sincerely,

Dr Mark Robinson MP