Chapter 4

Comments on the provisions of the Bill

4.1 In addition to considerations of constitutionality, the committee also received much evidence concerning the definitions and language used in the Bill and the adequacy of the safeguards being proposed. This chapter examines these issues.

Definitions and language used in the Bill

4.2 The exposure draft Bill relies on the use of defined terms to give effect to its objective, which, as set out in clause 3, is 'to recognise the right of a mentally competent adult who is suffering intolerably from a terminal illness to request a medical practitioner to provide medical services that allows the person to end his or her life peacefully, humanely and with dignity'.[1]

What is a 'dying with dignity medical service'?

4.3 Clauses 4 and 5 of the exposure draft Bill define a 'dying with dignity medical service' as 'a medical service provided by a medical practitioner to a person to enable the person to end his or her life in a humane manner' and specify that such services include:

- the giving of information to the person; and
- the prescribing of a substance to the person; and
- the preparation of a substance for the person; and
- the giving of a substance to the person for self-administration; and
- the administration of a substance to the person at the person's request.[2]

4.4 Throughout its inquiry the committee received evidence from submitters and witnesses who suggested that the definition of a dying with dignity medical service set out in the Bill required clarification. It appeared that there are some stakeholders who consider that voluntary euthanasia is occurring now, referred to as the principle of 'double effect', while others consider that this is simply good medical practice.

4.5 The Australian Medical Association (AMA) explained the need to clarify this situation by providing a clearer definition of 'dying with dignity medical service' in the Bill:

> In its definition of 'dying with dignity medical service', it is essential that this Bill clearly identify, and separate, interventions that are currently accepted as good medical practice from those that are not accepted as such (eg., any practice defined as euthanasia and/or physician assisted suicide).

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[1] Clause 3, Exposure Draft Bill.

[2] Clause 5, Exposure Draft Bill.

> The AMA believes the following activities do not constitute euthanasia or physician assisted suicide (where taken in accordance with good medical practice):
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> - not initiating life-prolonging measures;
> - not continuing life-prolonging measures;
> - the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.[3]

4.6 The AMA cited that its view was also shared by the Medical Board of Australia and the Australia and New Zealand Society of Palliative Medicine:

> …Section 3.12 End of Life Care in its Code of Conduct for doctors, the Medical Board of Australia states that good medical practice involves:
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> > 3.12.4 Understanding that you do not have a duty to try to prolong life at all cost. However, you do have a duty to know when not to initiate and when to cease attempts at prolonging life, while ensuring that your patients receive appropriate relief from distress.
> >
> > 3.12.5 Accepting that patients have the right to refuse medical treatment or to request the withdrawal of treatment already started.
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> The Australia and New Zealand Society of Palliative Medicine (ANZSPM) recognises:
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> - Treatment that is appropriately titrated to relieve symptoms and has a secondary and unintended consequence of hastening death, is not euthanasia. Euthanasia and physician assisted suicide involve the primary, deliberate intention of causing the patient’s death. These activities have not gained wide-ranging ethical acceptance by the medical profession globally; indeed, the World Medical Association deems a doctor’s involvement in either activity to be unethical.
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> - Withholding and/or withdrawing life-sustaining treatment (if undertaken in accordance with good medical practice) allows the course of the person’s illness to progress naturally, which may result in death. In addition, the administration of treatment or other action to relieve symptoms which may have a secondary consequence of hastening death is undertaken with the primary intent to relieve the patient of distressing symptoms. It is important that these practices, which are ethically acceptable if done in accordance with good medical practice, are not confused with activities that constitute euthanasia and/or physician assisted suicide.[4]

4.7 This view was also shared by the Royal Australian College of General Practitioners (RACGP). The RACGP informed the committee:

> Whilst doctors have an ethical duty to preserve life, there is also a responsibility to relieve suffering.

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[3] Australian Medical Association, *Submission 24*, p. [2].

[4] Australian Medical Association, *Submission 24*, p. [2].

> Death should be allowed to occur with dignity and comfort when death is inevitable. If life sustaining treatments are not in the patient's best interests, there is no legal duty on the part of the doctor to provide them. Patients have the right to refuse treatment. When treatment is withheld or withdrawn in these circumstances, and a patient subsequently dies, the law classifies the cause of death as the patient's underlying condition and not the actions of others. Any legislation therefore needs to recognise that a number of existing forms of end of life care, which may hasten death, are recognised as good medical practice and do not constitute euthanasia or assisted suicide, namely:
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> - not initiating life-prolonging interventions
> - not continuing life-prolonging interventions
> - the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death (often referred to as the doctrine of double effect).[5]

4.8 Mr John Bond QC, representing Catholic Health Australia, argued that the Bill was clearly directed at euthanasia:

> The most critical thing to realise about the bill is that, unlike what I understand to be the sometimes difficult questions that clinicians face in applying the law of double effect—'Am I doing this to cause a death?', which would be wrong, or 'Am I doing this to alleviate?'—it might have the effect of accelerating death, which is lawful. This draft is not about anything blurry; this draft says that all of the services defined as dying with dignity services—even the advising—are to bring about the end of life. So it is always on that side of things.[6]

4.9 However, the Australian College of Nursing (ACN) suggested that the definition of 'dying with dignity medical service' required clarification, on the basis that the existing definition set out in the Bill is too broad:

> The proposed Bill does not make clear what constitutes a dying with dignity medical service and what services may be provided. Section 5 (1) defines dying with dignity medical services as "a medical service provided by a medical practitioner to a person to enable the person to end his or her life in a humane manner". The meaning of this definition is broad and may include a range of services. Further, the meaning of 'humane' is not defined and is open to subjective interpretation, as are the means by which the service is delivered. The proposed Bill further needs to clarify the context and environment in which the service is provided. For example, many people choose the setting in which they will die and these include residential aged care facilities, at home, acute or palliative care settings. The proposed Bill omits any reference to the setting or environment where dying with dignity medical services may be delivered and the requirements for dying with

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[5] Royal Australian College of General Practitioners, *Submission 51*, p. 1.

[6] Mr John Bond QC, Catholic Health Australia, *Proof Committee Hansard*, 15 October 2014, p. 52.

> dignity medical services which may be specific to particular settings. Without precise definitions and clear boundaries on the type of service and measures of service quality, potential for great variability in services and quality exists.[7]

4.10 Other submitters, however, suggested that reference to the term 'dying with dignity medical service' clouded the issue by not making reference to 'euthanasia' in the Bill.[8] Dr David van Gend explained:

> Statutes should be precise instruments using precise language, not an exercise in euphemism and obfuscation. Language is mangled by the euphemism at the heart of this Bill ('dying with dignity medical services' instead of 'ending the patient's life'). As a palliative care practitioner, my services are always directed to helping a patient 'die with dignity', but that means attending to distressing symptoms to achieve a gentle death, not making the patient die.
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> Any proposal to legalise a previously criminal act should at least dare to speak its name clearly and unflinchingly, not commit the offense of 'euphemasia'…[9]

Concerns the definition is too broad

4.11 Clause 4 of the Bill defines 'terminal illness' as 'in relation to a person, means an illness which, in reasonable medical judgment will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the person, result in the death of the person'.[10]

4.12 This proposed definition attracted much discussion throughout the committee's inquiry, particularly as the definition does not link death to a timeframe.

4.13 The Medical Oncology Group of Australia made the point:

> A terminal illness has no precise definition but would usually be characterised as one where death from an incurable illness is expected to occur within weeks and almost certainly in less than six months. This is generally what is used for other medical situations, such as admission to a hospice. The terminal nature of the illness should be determined as objectively as practical. Using cancer as an example, the diagnosis should be proven by biopsy and a prognosis provided by the patient's own cancer specialist and at least one other cancer specialist not directly involved in the patient's care.[11]

4.14 Dr Wendy Bonython, an academic from the University of Canberra, also expressed the need for a clearer definition of 'terminal illness':

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[7] Australian College of Nursing, *Submission 57*, p. [1].

[8] See, ACL, *Submission 48*, pp. 3–4; and Dr David van Gend, *Submission 53* , p. 12.

[9] Dr David van Gend, *Submission 53*, p. 12.

[10] Clause 4, Exposure Draft Bill 2014.

[11] Medical Oncology Group of Australia (MOGA), *Submission 9*, p. 1.

> I think you need to think very carefully about the scope of operation. If you are talking about somebody with mental illness who is prone to suicidal ideation, for example, from their perspective they may view that their condition is non-responsive and therefore terminal. If you want to limit it to people who say, 'This is a terminal illness which will kill me within a set time frame,' as opposed to, 'This is a chronic illness which I am going to die with rather than of,' this is something that I think needs to be clearly articulated.
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> I would be more concerned about terminology being used without it necessarily having been thought through and defined…[Is it] going to be limited to people who have a clear prognosis that the cancer is not going to go away and who are talking about life expectancy in terms of weeks and months, or are you looking at extending it to people who may have something ultimately like a genetic predisposition to a type of cancer but do not have any actual transition to the disease state yet? I think it is important that the terminology around what a terminal disease is for the purposes of this bill be really, really clear.[12]

4.15 The view commonly raised was that, by not setting out a clearer definition, dying with dignity medical services would be available to many people with incurable, yet treatable diseases, including diabetes. The Coalition for the Defence of Human Life gave the examples to illustrate this issue:

> For example, as soon as a person was diagnosed with an illness such as Type 2 diabetes or any form of dementia he or she could qualify. General frailty from old age may also meet the definition of "a degeneration of mental or physical faculties" that will "ultimately result in…death".[13]

4.16 This concern was also raised by the Anglican Archdiocese of Sydney:

> The definition of terminal illness makes no reference to a prognosis. This is extremely problematic, as it potentially makes euthanasia and PAS available to people who could live for a very long time. Some illnesses, for example prostate or breast cancer, diabetes or renal failure, and some injuries, for example paraplegia, can have prognoses of over a decade. That is, we are not necessarily talking about people who are imminently dying. This creates a real risk that the Bill will end up making suicide available to a far wider range of people than is intended. Furthermore, even in the instance of a terminally ill patient, it is well known in the medical community that the art of prognosis is extremely difficult and errors are often made.[14]

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[12] Dr Wendy Bonython, University of Canberra, *Proof Committee Hansard*, 3 October 2014, p. 48.

[13] Coalition for the Defence of Human Life, *Submission 1*, p. 9.

[14] Anglican Diocese of Sydney, *Submission 27*, p. 6. This view was also raised in submissions received from the Presbyterian Church of Tasmania, *Submission 30*, p. 1; Monica Doumit, *Submission 31*, p. [2]; and Dr David van Gend, *Submission 53*, p. 12.

4.17 In contrast, Christians Supporting Choice for Voluntary Euthanasia commended the flexibility which the definition would provide by not specifying a timeframe in which death is to occur:

> I took heart when reading the law that you had drafted, thinking that by not saying that you have to be terminally ill, diagnosed to die within six months.
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> … Please, do not put a time limit on it, because, as it is now, I believe that it does open it up for people in the early stages of Alzheimer's… I can give you an example of a case where a fellow diagnosed himself as having Alzheimer's…He found himself driving in the wrong area, and then a few other things started happening. He realised, because he was in his 70s, 'I'm starting to lose it.' So he put his affairs in order, got a new, smaller car, made sure his wife was sorted out and then jumped off a cliff. Now, he probably had several years of good-quality life left before he got to the stage where he was no longer aware of what was happening around him. But he so feared Alzheimer's, or whatever cause of dementia it was, that he committed suicide far earlier than he otherwise would have. I believe a lot of the suicides by the aged in our society that we read about are by people trying to control their death, rather than relying on palliative care specialists who might or might not have sympathy for their plea to help them die.[15]

Concerns the definition is too narrow

4.18 In contrast to the concerns of submitters that terminal illness should be more clearly defined, some submitters argued that the Bill should apply more widely than just to those with a terminal illness. For example, Dying with Dignity NSW recommended that the 'eligibility criteria' be widened to 'include people experiencing unrelievable suffering from serious degenerative diseases and catastrophic injury'.[16]

4.19 The Voluntary Euthanasia Party of NSW expressed a similar view:

> The VEP believes that any competent adult suffering from a terminal or incurable illness or condition who is experiencing unrelievable suffering should have the right to access this law when it is introduced. Therefore we support a definition of 'illness' and 'terminal illness' that is broad enough to include progressive conditions such as multiple sclerosis and motor neuron disease.
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> We would prefer 'illness' to be referred to within the bill as an 'Eligible medical condition'.
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> The Tasmanian Voluntary Assisted Dying Bill 2013, for example, refers to an 'Eligible medical condition' and defines this as:
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> Eligible medical condition

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[15] Mr Geoffrey Williams, Christians Supporting Choice for Voluntary Euthanasia, *Proof Committee Hansard*, 3 October 2014, p. 39.

[16] Dying With Dignity NSW, *Submission 58,* pp. 9–10.

> (1) For the purposes of this Act, an eligible medical condition is an incurable and irreversible medical condition, whether caused by illness, disease or injury –
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> (a) that would result in the death of a person diagnosed with the medical condition and that is causing persistent and not relievable suffering for the person that is intolerable for the person; or
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> (b) that is a progressive medical condition that is causing persistent and not relievable suffering, for a person diagnosed with the medical condition, that is intolerable for the person – and that is in the advanced stages with no reasonable prospect of a permanent improvement in the person's medical condition.
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> (2) For the avoidance of doubt, a person does not have an eligible medical condition solely because of the age of the person, any disability of the person or any psychological illness of the person.[17]

4.20 This view was also expressed by Dr Christopher Ryan, a consultant psychiatrist specialising in the assessment and management of people with medical illness:

> I think it probably is unfair to just apply it to somebody with a terminal illness. There have been cases in the UK recently where people who did not have a terminal illness but who had had strokes that led them to a situation where they found their lives unbearable and where they could not end their own lives—except by starving themselves—were not able to access legislation that was just for people with a terminal illness. They were in a situation where they had to, in this case, starve themselves. This is a very small number of people—a tiny number of people. I would have thought, in the best of all possible worlds, you would design legislation that would also take account of that tiny number of people. I recognise, though, the wider you make the legislation, the more people will, understandably, worry that perhaps some people will access the legislation who are not the sort of people we want to access the legislation.
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> …I would think it should be possible for legislation to include those small numbers of people but not create a list of more people being involved. I recognise that there is a tension there. In my opinion, it is possible to do; but I have sympathy for people who say: 'No, hang on. That's bad luck for those two or three people. They're just going to have to suffer.' That is fine, although it does mean actual suffering for those few people.[18]

4.21 In addition to the terms defined in clause 4, other language used in the Bill also attracted comment. Some submitters were critical of the terms 'clinical depression' and 'soundness of mind' on the basis that they were not defined or better explained in the exposure draft Bill. These matters are discussed below.

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[17] VEP, *Submission 61*, p. 11. Other submitters of a similar view included: 9 Concerned Citizens, *Submission 12*, pp. 1–3; Dying with Dignity Tasmania, *Submission 45*, p. 6; DIGNITAS, *Submission 67*, p. 20.

[18] Dr Christopher Ryan, *Proof Committee Hansard*, 3 October 2014, p. 15.

The adequacy of safeguards in the Bill

4.22 In seeking to achieve its objective, the Bill proposes a number of pre-conditions in clause 12 that must be satisfied before a person can access dying with dignity medical services.

4.23 Clause 12 would require that the person making the request be at least 18 years of age and an Australian resident.[19] It also sets out that the request by that person must be considered by three medical practitioners.[20] The requirements prescribed in the draft Bill on the medical practitioners are:

- A first medical practitioner must be satisfied on reasonable grounds that:
  - the person is suffering from a terminal illness; and
  - in reasonable medical judgement, there is no medical measure acceptable to the person that can reasonably be undertaken in the hope of effecting a cure; and
  - any medical treatment reasonably available to the person is limited to the relief of pain, suffering, distress or indignity with the object of allowing the person to die a comfortable death.[21]
- A second medical practitioner, who holds qualifications or experience in the treatment of the terminal illness from which the person is suffering, is then required to have examined the person and confirmed:
  - the first medical practitioner's opinion as to the existence and seriousness of the illness; and
  - that the person is likely to die as a result of the illness; and
  - the first medical practitioner's prognosis.[22]
- A third medical practitioner, who is a qualified psychiatrist, is then required to have examined the person and confirmed that the person is not suffering from a treatable clinical depression in respect of the illness.[23]

4.24 In addition, the Bill would further require, among other things, that before providing the dying with dignity medical services, the first medical practitioner is satisfied that:

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[19] Subclause 12(1)(a) and 12(1)(b), Exposure Draft Bill.

[20] Subclause 12(1)(c), 12(1)(d) and 12(1)(e), Exposure Draft Bill.

[21] Subclause 12(1)(c), Exposure Draft Bill. Clause 12 of the Bill also prescribes that if the first medical practitioner has no special qualifications in the field of palliative care, a further condition is that, the information to be provided to the person on the availability of palliative care options, must be given by another medical practitioner who has such special qualifications in the field – this can be the second or third medical practitioner – see subclause 12(2), Exposure Draft Bill.

[22] Subclause 12(1)(d), Exposure Draft Bill.

[23] Subclause 12(1)(e), Exposure Draft Bill.

- the person has considered the possible implications of the person's decision on his or her family;[24] and
- the person is of sound mind and that the person's decision to end his or her life has been made freely, voluntarily and after due consideration.[25]

4.25 These pre-conditions are intended to provide safeguards to protect vulnerable individuals, however, throughout the course of the committee's inquiry, the adequacy of the language used in the proposed provisions was questioned.

The requirement for a psychiatric assessment by a third medical practitioner

4.26 In addition to an assessment by two medical practitioners, the Bill would require that a third medical practitioner, 'who is a qualified psychiatrist has examined the person and has confirmed that the person is not suffering from a treatable clinical depression in respect of the illness'.[26]

4.27 This requirement was questioned by some submitters who suggested that it would restrict the access of people living in rural, regional and remote areas of Australia to dying with dignity medical services.[27] Dr Roderick McKay of the Australian and New Zealand Royal College of Psychiatrists (RANZCP) explained that in his view, access issues faced by those in rural and regional areas were not insurmountable:

> The availability of and access to psychiatrists is clearly an issue in rural Australia, but it is also one which is clearly being addressed in a wide range of fashions across Australia. I do not believe this should pose a block to access such that it would discriminate against a person who lives within rural areas. This can be through not only the availability of transport but also can be through the availability of video technology, which has definitely been progressively improving. The college would be of a view that a face-to-face assessment would always be preferable, but I think using video assessment would be the minimum standard that could be expected as a third opinion in this case.[28]

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[24] Subclause 12(1)(j), Exposure Draft Bill.

[25] Subclause 12(1)(k), Exposure Draft Bill.

[26] Subclause 12(1)(e), Exposure Draft Bill.

[27] Health Care Consumers Association of the ACT Inc, *Submission 38*, p. 7; Dying with Dignity Tasmania, *Submission 45*, pp. 6–7; Australian College of Nursing, *Submission* 57, pp. [2–3]; Dying with Dignity NSW, *Submission 58*, p. 11; COTA Australia, *Proof Committee Hansard*, 3 October 2014, p. 1; Dr Megan Best, Anglican Diocese of Sydney, *Proof Committee Hansard*, 3 October 2014, p. 25; Dr Gavi Ansara, National LGBTI Health Alliance, *Proof Committee Hansard*, 3 October 2014, pp. 42–43;

[28] Dr Roderick McKay, Australian and New Zealand Royal College of Psychiatrists, *Proof Committee Hansard*, 15 October 2014, p. 2. COTA Australia also suggested options for overcoming the issues faced by those in rural and regional locations. See, Ms Jo Root, COTA Australia, *Proof Committee Hansard*, 3 October 2014, p. 4.

4.28 In addition to the concerns relating to those located in rural and regional Australia, some suggested that the requirement for three medical practitioners was unnecessary. The Rationalist Society of Australia expressed the view that this requirement would add 'complication and stress':

> The Bill already mandates that the first medical practitioner be satisfied, on reasonable grounds, that the person is of sound mind and that the person's decision to end their life has been made freely, and has informed the person of counselling and psychiatric services available; and that this first medical opinion be confirmed by a second opinion. To mandate a third professional opinion is excessive and would add complication and stress to the process.[29]

4.29 The requirement however for a third medical practitioner who is a qualified psychiatrist to examine the person and confirm that they were not suffering from treatable clinical depression was seen by others as a necessary and prudent safeguard. Dr Christopher Ryan, a consultant psychiatrist who has written extensively on the role of psychiatry in end of life care and decision making, informed the committee that, in his view:

> This goes to my contention that the mandatory psychiatric review, which is already part of the draft bill, should remain part of the draft bill. There are two ways to look at this argument. One is that if you add another person that the terminally ill person, who is in dire straits and wants to end their life, has to see then this is an extra burden for them, and it is likely to lead to at least some delays, particularly in rural areas. That is definitely a negative of having a mandatory psychiatric review; I think that is just the case. The positive side of that is that you are less likely to get the problems that probably exist in Oregon, where, even though people cannot access physician assisted dying in Oregon if they are depressed, there is no mandatory psychiatric review; it just depends on your physicians noticing that you are depressed, or delirious, and then referring you off to somebody who can check that out. That would be fine if we were confident that physicians were able to do that well. We know, and there is data that shows, that they are not; they often miss depression in the context of terminal illness, and they often miss delirium in the context of terminal illness.
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> The worry would be that without that additional mandated safeguard then you would get some people falling through the cracks. To be honest, it is probably not a huge number. Then it is just a question of people's preferences: are you prepared to let the odd person fall through the cracks to avoid everyone being further inconvenienced by yet another hoop that they have to jump through, or are you not?
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> Perhaps because of my profession, and also because I really do not like the idea of people being killed when they have not really made advance

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[29] Rationalist Society of Australia, *Submission 42*, p. 1. See also, Voluntary Euthanasia Party, *Submission 61*, p. 13; and DIGNITAS, *Submission 61*, p. 25.

> decisions that they want to be, my inclination is for adding the extra safeguard—despite the fact that I recognise that that is an impost.[30]

4.30 Dr Ryan explained to the committee however, that although a person may be suffering from clinical depression that does not mean that their capacity to make decisions is impeded. Dr Ryan explained that to make that determination regarding capacity, it was necessary for a psychiatrist to be involved.

Sound mind

4.31 Submitters raised concerns with the language in subclause 12(1)(k) requiring that the person making the request be of 'sound mind'. This terminology contrasts with that used in the objective in clause 3 which refers to a 'mentally competent adult'. COTA Australia explained this view to the committee:

> We are happy that an illness that includes degeneration of mental faculties should be included in the scope of any such bill—because obviously we have people with dementia and other degenerative diseases that impair their mental faculties. I guess it is an issue of timing. The bill goes on to say that you have to be of sound mind and competent at the time of making the request. That seems to be a little bit at odds. We are not talking about people having an advance health directive that includes involuntary euthanasia—'In case I lose my mental faculties I want X'—you have to actually be in the situation at the time. We think that is something that needs teasing out and perhaps discussion with people better qualified than me to think of how we might get around that. But we are just flagging that is an issue.[31]

4.32 Many submitters suggested that the reference to 'sound mind' should be changed. Dr Ryan explained to the committee that the term 'sound mind' 'is a rather archaic term for a modern legislation' and suggested that the term 'impaired decision-making capacity' or 'a loss of decision-making capacity' be used.[32] Dr Roderick McKay, of the Australian and New Zealand Royal College of Psychiatrists (ANZRCP) agreed that it would be preferable to refer to 'decision-making capacity' rather than soundness of mind.[33]

Other matters

4.33 Some submitters also questioned the pre-condition requirement set out in the Bill that, in determining the request for a dying with dignity medical service, the first medical doctor must ensure that the person has considered the impact of their decision on their family.

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[30] Dr Christopher Ryan, *Proof Committee Hansard*, 3 October 2014, p. 14.

[31] Ms Jo Root, COTA Australia, *Proof Committee Hansard*, 3 October 2014, p. 2.

[32] Dr Christopher Ryan, *Proof Committee Hansard*, 3 October 2014, p. 12.

[33] Dr Roderick McKay, Royal Australian and New Zealand College of Psychiatrists, *Proof Committee Hansard*, 15 October 2014, p. 2.

4.34 This was identified as a particular issue for the lesbian, gay, bisexual, transgender and intersex (LGBTI) community. For example, the National LGBTI Health Alliance explained:

> According to Section 12, point 1 under item (j) (p. 6, lines 30–32), the first medical practitioner must be satisfied that the person has considered the possible implications of the person's decision on their 'family'. Thus access to end-of-life medical services is affected by which individuals are determined to constitute 'family'. Yet no protection is provided to ensure that people can have their designated family present and can bar those biological relatives who are typically assumed to constitute 'family'. Protection from unwanted involvement by biological relatives is important, given the lack of support and acceptance that many LGBTI people experience from their biological relatives.[34]

4.35 Liberty Victoria also expressed support for removing this requirement on the basis of personal autonomy:

> The decision is a personal one. It is not a decision for the family. It is not for the law to say that whether or not somebody should make a decision to end their life should depend on whether or not adequate consideration is given to what members of their family think.
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> …One cannot generalise about familial experience. I go back to the major point: this is not a criterion that ought to be determinative of whether or not a person can seek to end their life…It is not for the law to say, 'We are going to your family, no matter what kind of relationship you have with them, and what your family says is going to be the significant factor in making a decision about whether you can end your life.' It is simply inappropriate.

4.36 COTA Australia shared a similar view, stating that the requirement for the medical practitioner to ensure that the person has considered the implications on their family:

> [U]ndermines the basic principle of respecting an individual’s right to choose. It is also not clear how the medical practitioner could satisfy themselves with regard to this.[35]

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[34] National LGBTI Health Alliance, *Submission 90*, p. 4.

[35] COTA Australia, *Submission 14*, p. 5. Dying with Dignity ACT, in its submission to the committee made a similar point stating: ' I query the need for the first medical practitioner to be satisfied that the person has considered the possible implications of the person’s decision on his or her family. This provision is unreasonable and unkind. It implies that the person should feel guilty about not dying because of her/his disease'. See, *Submission 89*, p. 2.