The Senate

Legal and Constitutional Affairs Legislation Committee

Medical Services (Dying with Dignity) Exposure Draft Bill 2014

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Mr Simon Jones, Administrative Officer

Ms Jo-Anne Holmes, Administrative Officer

Suite S1.61	Telephone:	(02) 6277 3560
Parliament House	Fax:	(02) 6277 5794
CANBERRA ACT 2600	Email:	legcon.sen@aph.gov.au

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Chapter 1
Introduction

The referral

1.1 On 24 June 2014 the Senate referred the Medical Services (Dying with Dignity) Exposure Draft Bill 2014 (the Bill), to the Legal and Constitutional Affairs Legislation Committee for inquiry and report by 27 October 2014.[1] In referring the exposure draft of the Bill, the Senate requested that the committee have regard to the rights of terminally ill people to seek assistance in ending their lives, and an appropriate framework and safeguards with which to do so.[2]

Background

1.2 The Bill before the committee is a Private Senator's exposure draft Bill. It has been prepared by Senator Richard Di Natale of the Australian Greens.

1.3 The Bill is comprised of five Parts:

- Proposed Part 1 sets out clauses 1 to 9 which include the objectives of the Bill, key definitions and the constitutional basis for the Bill. The objectives of the Bill, as set out in clause 3, are:

  > (a) 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; and
  >
  > (b) to grant a medical practitioner who provides such services immunity from liability in civil, criminal and disciplinary proceedings.[3]

- Proposed Part 2 (Dying with dignity medical services) sets out clauses 10 to 15 of the Bill. Clauses 10 to 15 of the Bill contain the key provisions, including the ability to request dying with dignity medical services, pre-conditions that must be met to access dying with dignity medical services, as well as additional requirements and provisions concerning rescinding a request. The pre-conditions set out in clause 12, as well as the proposed provisions of clauses 13, 14 and 15 are intended to provide safeguards. These provisions attracted considerable comment in both submissions and public hearings.
- Proposed Part 3 (administrative arrangements) of the Bill contains clauses 16 to 20. The clauses include provisions for payment of the medical practitioner. They also set out the record-keeping obligations for medical practitioners who provide dying with dignity medical services.

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1 *Journals of the Senate*, No. 35—24 June 2014, p. 976.

2 *Journals of the Senate*, No. 35—24 June 2014, p. 976.

3 Clause 3, Medical Services (Dying with Dignity) Exposure Draft Bill 2014.

- Proposed Part 4 (Offences) sets out clauses 21 to 23. Clauses 21 to 23 of the Bill contain offence provisions, including a provision which will make it an offence for a person to influence a medical practitioner in relation to dying with dignity services, and another which will create an offence if a medical practitioner fails to keep records.
- Proposed Part 5 (Other matters) contains clauses 24 to 27. Clauses 24 and 25 exempt persons acting under the proposed Act from civil, criminal and disciplinary actions and provide such persons with immunity from offences.

Conduct of the inquiry

1.4 The committee advertised the inquiry in *The Australian* newspaper on 2 July 2014. Details of the inquiry were published on the committee's website at www.aph.gov.au/senate_legcon. The committee also made a pro forma submission available on its website. The questions set out in the pro forma submission are attached at Appendix 1. The pro forma submission was completed by over 4,700 submitters. Approximately 54 per cent of people who completed the pro forma submission expressed support for the proposal set out in the Bill, 44.7 per cent opposed the proposal and the remaining were undecided. In addition, the committee wrote to over 150 organisations and individuals inviting submissions by 21 August 2014.

1.5 The committee received over 700 submissions. Owing to the large number of submissions received, the committee decided not to publish all submissions on its website. Instead, an equal number of randomly selected individual submissions (both supporting and opposing the Bill) were published in addition to all submissions received from organisations and academics. A list of the submissions published is at Appendix 2.

1.6 Public hearings were held on Friday 3 October 2014 in Canberra and Wednesday 15 October 2014 in Melbourne. A list of witnesses who appeared at the public hearings is at Appendix 3. The *Hansard* transcripts of the committee's hearings can be accessed on the committee's website.

1.7 The committee wishes to acknowledge that whilst the Bill exists within a broader policy debate on voluntary euthanasia, it resolved early in the inquiry that it would focus on the provisions of the exposure draft Bill rather than this broader debate. The committee therefore did not seek to inquire into voluntary euthanasia more generally and this report should be considered in that context.

Acknowledgment

1.8 The committee acknowledges the large volume of evidence it received throughout its inquiry and thanks submitters for their contributions to the inquiry through submissions and the giving of evidence at public hearings. The committee is especially grateful to those who courageously shared their very personal experiences.

1.9 As set out above, in paragraphs 1.4 to 1.6, the committee received a broad cross section of views in relation to the Bill. Although it was not possible to hear from

all submitters at public hearings, the committee did hear from stakeholders representative of the range of views held.

Note on references

1.10 References in the report to the committee *Hansard* are to the proof committee *Hansard*. Page numbers between the proof committee *Hansard* and the official *Hansard* may differ.

Structure of the report

1.11 The report is comprised of five chapters:

- This chapter introduces the inquiry and explains the process undertaken by the committee.
- Chapter 2 provides an outline of the views raised by submitters both supporting and opposing voluntary euthanasia.
- Chapter 3 examines the questions raised in respect of the constitutional validity of the Bill in terms of the authority of the Commonwealth to legislate in respect of voluntary euthanasia.
- Chapter 4 examines issues raised in respect of the key provisions of the exposure draft bill.
- Chapter 5 sets out the committee's comments and recommendations.

Chapter 2
Responses to the Bill

2.1 Many submitters to the inquiry commented on the broader policy issue of voluntary euthanasia, expressing both support for, and opposition to its introduction. The volume of submissions received, which included over 4700 pro forma submissions and over 700 additional submissions, indicated the community's broad engagement with this issue.

2.2 This chapter looks briefly at the main issues that were argued by each side of the debate.

Support for reform

2.3 Many submitters explained their support for the Bill on the basis that voluntary euthanasia is currently taking place and that it would in fact be better for there to be legislation regulating the practice.

2.4 Mr Peter Short, an individual with terminal cancer, explained this to the committee:

> …I very strongly believe, as I presently sit, that I will choose when and how I end my life. I would add to that, also, in terms of process and what goes on, it interesting to think about the concerns about ending life. Just to demonstrate, palliative care comes when you are a terminal person, and you are given this. It is an emergency pack. There are enough drugs in there to kill me and probably one or two of you. And that is just sitting in my house.
>
> As well as that, over the course of the last six years I have not been able to sleep sometimes and I get a few aches and pains, so this is the standard set of three drugs I have: Diazepam, Ativan and valium. I do not use them very often but again there is enough drugs in there, sensibly prescribed, that would kill me. The issue is that I want to have a controlled process in an environment where I know that it is going to be a magnificent death and a magnificent ending not, as you mentioned before, swallowing a whole lot of pills, hoping it works and spitting half of them back up.[1]

2.5 Mr Short further explained that the possibility of having control over the process of his dying gave him an 'inner glow of certainty' of not having to worry when he gets to the stage of dying:

> If this bill passes, I may be the only person in the country that ever uses it—because, again, it is a choice—but it also alleviates my concern about how I will exit this world in terms of relationship with my wife and my child,

1 Mr Peter Short, *Proof Committee Hansard*, 15 October 2014, p. 31.

> because I know that, if I choose to, we can have a very sensible, peaceful conversation at a time of our choosing.[2]

2.6 These views were echoed by Professor Margaret Otlowski who informed the committee that empirical data 'drives the need for legislative reform':

> We need to recognise that euthanasia is occurring in practice and, in order to provide safeguards for patients, and also for doctors who provide such assistance, we need to put in place a legislative regime that allows appropriate scrutiny, support and regulation.
>
> …it is not a question of whether we should commence to allow euthanasia, or for it to occur; it is already occurring. It is rather a question of: do we continue to ignore it and pretend that a prohibition is effective; or do we act more openly and honestly, and recognise that it is happening in practice, and put in place a regime that seeks to regulate it in a safe manner?
>
> …in countries which prohibit euthanasia, not only is there still a similar level of practice but there is actually more danger to patients because there is a higher level of unrequested killing, because doctors clearly are not in a position to have open discussions and may act in the absence of an explicit request.
>
> There is also a clear reluctance for legal authorities to get involved. There are doctors who are admitting involvement, through open letters in the papers and so on, but there are no follow-up prosecutions. Even if there were prosecutions, based on precedents from other jurisdictions, there is every likelihood that doctors would be dealt with leniently. I really want to emphasise that this is all pointing to the fact that current criminal prohibitions do not reflect common views of reprehensibility. There is a need for reform.[3]

The role of the doctor

2.7 Some submitters to the inquiry argued that the Bill may compromise the historical role of the doctor as healer, which is inextricably linked to the Hippocratic Oath.[4] This however, is a contested view. Ethicist Dr Bernadette Tobin, while expressing support for the Hippocratic conception of medicine, explained that there is a current 'battle of ideas' concerning medicine:

> I think that there is a battle of ideas, and a battle of practices, going on within the medical profession at the moment: between those who are committed to a Hippocratic conception of medicine—healing; making whole—which embodies teaching, curing where possible, stabilising a person in a reasonably satisfactory condition, relieving pain, improving the

2 Mr Peter Short, *Proof Committee Hansard*, 15 October 2014, p. 31.

3 Professor Margaret Otlowski, *Proof Committee Hansard*, 15 October 2014, p. 8.

4 Salt Shakers, *Submission 19*, p. 2; Catholic Women's League of Australia, *Submission 2*, p. 1; Organisation of Rabbis of Australasia, *Submission 34*, p. 1; Australian Christian Lobby, *Submission 48*, p. 10; Professor Anthony Radford, *Submission 50*, p. 2; Lutheran Church of Australia, *Submission 39*, p. 2; Family Council of Victoria, *Submission 85*, pp. 2–3.

> way a person dies, and that range of activities; and then those that have a different view of medicine, which is a kind of provider/consumer conception—so the doctor is the provider and he or she can choose whatever he or she wants to provide, and to whom, and under what conditions, and the patient is a consumer and can ask for whatever he or she wants, in whatever way and under whatever conditions. So there is a battle of ideas going on at the moment…the latter is what I have in my submission called the value-neutral, provider-to-consumer option, and the former is an ethically infused conception of medicine, which I have called Hippocratic, because it goes back to the Hippocratic Oath. In that oath, the point of medicine is explained, and the things that doctors, as doctors, will never do are also explained.[5]

2.8 Some submitters also suggested that the introduction of voluntary euthanasia would fundamentally undermine the relationship between a doctor and their patient. This was best expressed by Professor Roderick MacLeod who explained his concern that it would lead to an 'erosion of the level of trust between patient and doctor':

> Having legislation to legalise euthanasia or physician-assisted suicide would, I think, necessarily interfere with the bond of trust between doctor and patient.[6]

2.9 Professor MacLeod further explained:

> My sense is that part of the therapeutic benefit that I have with the people that I care for is built on trust. I would be concerned that if the patients thought, in building that sense of trust, that I might be the one that ended their life as well as tried to preserve their life, that would be a difficult thing for them to equilibrate. There is no evidence for that; it is just an opinion that I have that I see the key to effective medical care being based purely on trust.[7]

The slippery slope

2.10 Many submitters opposed to the exposure draft Bill suggested to the committee that introducing legislation to legalise voluntary euthanasia was a 'slippery slope' which would lead to euthanasia without specific consent or in non-terminal cases. Many submitters referring to the experience of Dutch Ethicist Theo Boer, himself an architect of the Netherlands voluntary euthanasia legislation. For example, the Catholic Women's League of Australia stated:

> In mid-July, as peers in the House of Lords in the UK, prepared to debate the Assisted Dying Bill, promoted by a Lord Falconer, Professor Boer urged them 'don't make our mistake' and warned of a 'slippery slope' to mass deaths. He further advised that assisted deaths have increased by

5 Dr Bernadette Tobin, Plunkett Centre for Ethics, *Proof Committee Hansard*, 15 October 2014, p. 36.

6 Professor Roderick MacLeod, *Proof Committee Hansard*, 15 October 2014, p. 23.

7 Professor Roderick MacLeod, *Proof Committee Hansard*, 15 October 2014, p. 23.

> approximately 15% every year since 2008 and the number could reach a record 6,000 by the end of 2014.[8]

2.11 The Australian Christian Lobby (ACL) explained:

> [W]e have clearly seen the slippery slope well and truly in action in Holland and in Belgium, in particular, where we have seen people being euthanised without their specific consent. That is not voluntary euthanasia.[9]

2.12 The ACL further explained:

> Once you go down this path, it is very hard to regulate the motives of people, whether it is family or others. There are very complex human motivations that come into end-of-life issues…And I think in reality you would be talking about this being available to a very, very small cohort of people who would fit a very narrow definition of what was acceptable. And then I think the question goes to whether hard and difficult and tragic cases make good public policy, good law, and I think generally we find as a principle of public policy that hard cases do not make good law.[10]

2.13 Mr Craig Wallace of Lives Worth Living raised a similar argument:

> Arguments about slippery slopes often have the odour of intellectual bankruptcy. Yet, with this issue, there actually does seem to be a slope. In every jurisdiction where it has been introduced euthanasia has spread to a much wider group of people than was intended. My mind was crystallised on this issue by the case in Belgium of the two twins who were deaf and had Usher syndrome and who were perfectly healthy but feared going blind and were granted euthanasia.[11]

2.14 In a paper Dr Christopher Ryan, a consultant psychiatrist, authored in the Australian and New Zealand Journal of Psychiatry, Dr Ryan was critical of the 'slippery slope' argument:

> The slippery slope arguments do not set out to show that there is anything intrinsically wrong with AVE, but rather maintain that the legalisation of AVE and its moral acceptance would inevitably lead to a deterioration of moral standards resulting in clearly unacceptable consequences. This deterioration is envisaged to take place in one of two ways. First, it may be that no logical distinction can be drawn between the allowable acts and the

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8 Catholic Women's League of Australia, *Submission 2*, p. 2. Professor Boer's warning of a slippery-slope was raised in *Submission 4*, Not Dead Yet UK; *Submission 8*, Evangelicals for Life; *Submission 19*, Salt Shakers; *Submission 27*, Anglican Diocese of Sydney; *Submission 30*, The Presbyterian Church of Tasmania; *Submission 52*, The Right to Life Australia Inc.; *Submission 53*, Dr David van Gend; *Submission 180*, HOPE: preventing euthanasia and assisted suicide; as well as a number of form letters received by the committee.

9 Mr Lyle Shelton, Australian Christian Lobby, *Proof Committee Hansard*, 3 October 2014, p. 60.

10 Mr Lyle Shelton, Australian Christian Lobby, *Proof Committee Hansard*, 3 October 2014, p. 60.

11 Mr Craig Wallace, Lives Worth Living, *Proof Committee Hansard*, 3 October 2014, pp. 18–19.

> unacceptable consequences. Second, even if a logical distinction can be found, the proponents of the slippery slope worry that society will not heed that distinction.
>
> Psychological and social factors will, once unleashed, trample on the niceties of logical distinctions and the feared consequences will unfold. In its fiercest form the slippery slope argument sees the legalisation of AVE as the beginning of a malignant and fulminating social decay.[12]

2.15 Professor Margaret Otlowski concurred with this view that the slippery slope argument is not based on the 'inherent wrongfulness of the individual act, but rather, on the practical consequences of legislation' and informed the committee that the arguments put forward are 'completely unsubstantiated':

> The most commonly cited objection to the legalisation of active voluntary euthanasia is the 'slippery slope' argument: that the legalisation of active voluntary euthanasia would lead to widespread involuntary euthanasia and the termination of lives no longer considered socially useful. This is, however, a completely unsubstantiated argument. The 'slippery slope' argument is typically made without regard to the risks of abuse or other problems involved in *retaining* the present law.[13]

2.16 Dr Ryan, when asked of his views on the idea of voluntary euthanasia being introduced into the Netherlands, explained that the argument of the 'slippery slope' had, in his view, been disproven even though he did not consider the model used in the Netherlands to be an optimal approach:

> As I said, I am not a particular fan of the way that the Netherlands have constructed their access to the euthanasia regime. It has not been constructed in the way that we construct things. It is very much a European and particularly a Dutch way of doing it. I am sure the committee would know that, originally, it was not legislation; it was that you could kill your patient, but you would not be prosecuted if you did certain things. Those things were codified and then that was turned into legislation. I do not think the Netherlands is now a cesspool of people being killed willy-nilly, but I also do not think it has set things up as safely as it could have done. Oregon is a much better model. And I think an improved Oregon is an even better model.[14]

2.17 Professor Otlowski agreed with the view that the experience of the Netherlands 'debunks' the slippery slope argument:

> Certainly the Netherlands, for example, is a good model. I would suggest that it also debunks arguments about slippery slopes because there is now strong empirical evidence that, with such legislation in force, it can operate satisfactorily. There is a strong belief in the Netherlands that the majority of

12 Dr Christopher Ryan, Australian and New Zealand Journal of Psychiatry 1995; 29: 581.

13 Professor Margaret Otlowski, *Submission 56*, pp. 10–11.

14 Dr Christopher Ryan, *Proof Committee Hansard*, 3 October 2014, p. 16.

> cases are being openly reported now because doctors know that is the legal pathway.[15]

2.18 Christians Supporting Choice for Voluntary Euthanasia cited the Oregon experience as also supporting this view:

> From my understanding, in Oregon they have had this legislation for 17 years and they have done studies which have shown that this slippery slope you are referring to does not exist. It is a scaremongering tool used by those who are ideologically opposed to the proposed legislation and who will do anything they can to stop the law. We in Christians Supporting Choice side with loving compassion and mercy and not with religious dogmatic adherence to a particular point of view…There is no slippery slope.[16]

2.19 Mr Peter Short, appearing before the committee with a terminal diagnosis of oesophageal cancer, stated that in his view, '[t]he fact that people have coined a phrase for a key objection to the bill is to me both scary and demeaning', stating:

> Is it rational to take a position of denying the terminally ill and suffering the choice at the end of their life, because we are concerned we cannot put effective rules around a dying process? We manage road rules, alcohol rules and smoking rules. All are slippery slopes far more difficult and destructive, but all well-accepted in society and in law.[17]

2.20 Indeed, Dying with Dignity Victoria argued that a slippery slope was more likely to occur in an environment where voluntary euthanasia is prohibited rather than a society where a transparent, legislative framework regulates the occurrence.[18] This was a view shared by others,[19] including Professor Otlowski.[20]

The role of palliative care

2.21 Many submitters raised concerns that the introduction of voluntary euthanasia would undermine investment in, as well as the role and the value placed on palliative care:

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15 Professor Margaret Otlowski, University of Tasmania, *Proof Committee Hansard*, 15 October 2014, pp. 8–9.

16 Mr Geoffrey Williams, Christians Supporting Choice for Voluntary Euthanasia, *Proof Committee Hansard*, 3 October 2014, p. 38.

17 Mr Peter Short, *Proof Committee Hansard*, 3 October 2014, p. 30.

18 Ms Lesley Vick, President, Dying With Dignity Victoria, *Proof Committee Hansard*, 15 October 2014, p. 46.

19 See, SAVES, *Submission 3*, p. 1; Dying with Dignity NSW, *Submission 58*, p. 7; and Dr Rosemary Jones, *Submission 98*, p. 1.

20 Professor Margaret Otlowski, *Submission 56*, p. 11.

> There is also a danger that there would be reduced investment in improving palliative care by research and reduced need seen to increase the availability and access to palliative care.[21]

2.22 By contrast, Mr Peter Short, in sharing his experience with the committee explained how, in his view, the introduction of voluntary euthanasia would not undermine palliative care. Rather he suggested that it should be a part of the tool kit available in palliative care and medicine:

> [O]nly someone who is in my position can really understand this. People talk about the palliative process and people talk about the end as the last week or the last two weeks. I found out nine months ago I was going to die and at the start, straight away into the palliative process, fantastic people explained what I could expect. I explained that I wanted to die at home and went through those sorts of conversations and they explained that they would medicate me as needed and my doctors promised me that they would do everything in their power to ensure that I had as calm and as peaceful a death as possible.
>
> …People talk about palliative care as being a last-minute process with the drugs and the nurses and things. My palliative care journey started when, as soon as I was diagnosed, the family was introduced to a psychiatrist: 'Go and have a talk and get your head straight. You're going to go off the planet or not.' Maybe I have!…And then they come around and they just check up on me as we go.
>
> So the palliative care process, I think, is fantastic, and, the more we can invest in improving that, so be it. This is simply a tool that should be part of the palliative care process.[22]

2.23 Many submitters and those who gave evidence to the committee generally shared the view that there is a need for greater investment in palliative care and while many proponents of voluntary euthanasia see value in palliative care, they consider that euthanasia is required for those circumstances where even the best palliative care will not relieve the suffering or distress of a terminally ill patient.

2.24 For example, the South Australian Voluntary Euthanasia Society (SAVES) explained:

> It is widely acknowledged, including by Palliative Care Australia and the Australian Medical Association, that even the best of palliative care cannot help all patients – between 5-10% find their suffering so unbearable that they persistently request an assisted death. Our palliative and medical care is highly regarded, but it can never be 100% effective.[23]

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21 Mr Terri Kelleher, President, Australian Family Association, *Proof Committee Hansard*, 15 October 2014, p. 16. See also, Catholic Women's League of Victoria and Wagga Wagga, *Submission 7*, p. 1; and Knights of the Southern Cross, *Submission 11*, p. 1.

22 Mr Peter Short, *Proof Committee Hansard*, 15 October 2014, pp. 31–32.

23 South Australian Voluntary Euthanasia Society, *Submission 3*, p. 1.

2.25 Professor Roderick MacLeod, a palliative care specialist explained to the committee that in his experience, when people who are suffering ask for euthanasia what they are expressing is that they do not want to live as they currently are, and that in those circumstances:

> The skill of the palliative care team is to identify which of those elements can be readily dealt with and which will take time. Sometimes it is the physical elements which are the easiest to deal with and sometimes there are elements of suffering—so-called, which is why I have a difficulty with that concept—that cannot be relieved.[24]

2.26 Assistant Professor Andrew Cole, also a palliative care specialist, explained how the lack of training and experience in palliative care and medicine can cause suffering:

> There is a natural dying process that medical students are not taught well about. Dehydration is part of the natural dying process, and doctors often interfere with that and hydrate people unnecessarily and cause suffering. So dehydration, with the reduction of pain levels and so forth that goes with it, is not all bad.
>
> …hastening times is not necessarily the way forward. Rather, it is providing care and support, letting the natural processes take their course and choosing to withdraw therapies that are not reasonable or not helpful. I spend a lot of time with older patients stopping unnecessary medications for hypertension and all the other things that are just causing side effects. That is a perfectly appropriate part of medical care because medications that do good in one situation do not necessarily do good in another situation.[25]

2.27 Professor Cole explained that in his father's experience, palliative care was available and able to provide a peaceful outcome for the family.[26]

Public opinion

2.28 The committee received hundreds of submissions in support of the Bill, many from older Australians expressing the desire to have control in how they die and many stating that their views were based on personal experience.

2.29 The committee heard also that public opinion is shifting and that more than 80 per cent of the population is in favour of voluntary euthanasia:

> Opinion polls in Australia consistently show strong support for a regime of voluntary assisted dying. Polls taken by a variety of polling organisations over the last ten years have registered rates of support at between 70% and 85%.[27]

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24 Professor Roderick MacLeod, *Proof Committee Hansard*, 15 October, p. 25.

25 Professor Andrew Cole, *Proof Committee Hansard*, 15 October 2014, p. 29.

26 Professor Andrew Cole, *Proof Committee Hansard*, 15 October 2014, p. 29.

27 Dying with Dignity NSW, *Submission 58*, p. 8. See also, Australian Sex Party, *Submission 62*, pp. 2–3; Christians Supporting Choice for Voluntary Euthanasia, *Submission 86*, p. 2.

2.30 Some submitters however questioned the legitimacy of these statistics.[28] Clearly, many who are opposed to voluntary euthanasia do so passionately and for deeply held moral, religious or practical reasons.

28 For example, see, Australian Family Association Western Australian Division, *Submission 60*, pp. [2–3]; Anglican Church Diocese of Sydney, *Submission 27*, p. 6; and the ACT Right to Life Association, *Submission 49*, p. 1.

Chapter 3

Constitutionality of the Bill

The constitutionality of the Bill

3.1 Many submitters to the inquiry raised questions in relation to the constitutionality of the Bill, specifically the power of the Commonwealth Parliament to legislate for euthanasia.

3.2 Eight submissions considered this question in some detail[1] expressing the full range of views on the Bill's constitutionality. Some thought it was wholly valid or wholly invalid, whilst others thought it was valid in some respects, but not others.

3.3 Clauses 6 and 7 of the Bill address constitutional issues as follows:

> *6 Constitutional basis for this Act*
>
> This Act relies on:
>
> (a) the Commonwealth's legislative powers under paragraph 51(xxiiiA) of the Constitution; and
>
> (b) any implied legislative powers of the Commonwealth.
>
> *7 Additional operation of this Act*
>
> (1) Without prejudice to its effect apart from this section, this Act also has effect as provided by this section.
>
> (2) This Act has, by force of this subsection, the effect it would have if its operation were, by express provision, confined to a medical practitioner employed by a constitutional corporation.
>
> (3) This Act has, by force of this subsection, the effect it would have if its operation were, by express provision, confined to a person engaging in conduct to the extent to which the conduct takes place wholly or partly in a Territory.
>
> (4) In this section:
>
> *constitutional corporation* means a corporation to which paragraph 51(xx) of the Constitution applies.

3.4 Clause 6 affirmatively states two heads of power upon which the Bill rests: subsection 51(xxiiiA) of the *Constitution*, which allows for laws to be made with respect to—*inter alia*—the provision of medical services and 'pharmaceutical, sickness and hospital benefits'; and unnamed legislative powers that are to be implied as being held by the Commonwealth Parliament.

3.5 Clause 7 provides that, in addition to being of general application, the Bill operates as if it were specifically limited to medical practitioners who are employed by a 'constitutional corporation' and to conduct that takes place wholly or partly in a

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1 *Submission 1*, pp. 2–8; *Submission 6*, pp. 6–7; *Submission 21*, pp. 2–3; *Submission 36*, attachment; *Submission 40*, pp. 1–3; *Submission 47*; *Submission 53*, pp. 3–5; *Submission 87*, pp. 4–8.

Territory. It would appear to the committee that clause 7 seeks to operate as a 'backup' provision in case the Bill cannot rest on the heads of power relied upon in clause 6. If that were the case, the Bill would continue to operate in the circumstances described in clause 7 (as long as the Bill can rest on those heads of power in those circumstances).

The medical services power

3.6 Subsection 51(xxiiiA) of the *Constitution* provides as follows:

> The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to:
>
> …
>
> > (xxiiiA) the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances

3.7 The medical services power was inserted (following a referendum) by the *Constitution Alteration (Social Services) Act 1946*.

3.8 Four key questions were raised in evidence to the committee on the issue of whether the Bill could be supported by the medical services power, namely:

(i) whether 'dying with dignity medical services' are 'medical services' within the meaning of subsection 51(xxiiiA);

(ii) whether 'dying with dignity medical services' are 'pharmaceutical, sickness [or] hospital benefits' within the meaning of subsection 51(xxiiiA);

(iii) if (i) or (ii) are answered in the affirmative, whether the Bill is a law 'with respect to…the provision of' medical services or pharmaceutical, sickness or hospital benefits; and

(iv) whether the Bill violates the prohibition against 'civil conscription' in subsection 51(xxiiiA).

Meaning of 'medical service'

3.9 The first question is whether the provision of what the Bill calls a 'dying with dignity medical service' is a medical service within the meaning of subsection 51(xxiiiA) of the *Constitution*.

3.10 The range of views expressed in evidence to the committee regarding the characterisation of a 'dying with dignity medical service' as a 'medical service' included the following:

- 'a law will not be one with respect to the provision of medical services merely because it affects that which a medical practitioner may do';[2]
- the phrase 'medical service' does not have any special or technical meaning;[3]
- dictionaries do not define 'medical' and/or 'medicine' by reference to practices such as euthanasia, nor does contemporary Australian usage;[4]
- professional bodies such as the Australian Medical Association and the World Medical Association have expressed the view that medical practitioners should not assist in the practice of euthanasia;[5]
- the provision of certain services related to euthanasia were criminal acts at common law and under the laws of the States at the time that subsection 51(xxiiiA) was inserted into the *Constitution* in 1946 and remain so today;[6]
- whilst the range of services that fall within the phrase 'medical services' may change as a result of technological change, they must have at their core the 'diagnosis, treatment, and prevention of disease';[7]
- the provision of services related to euthanasia do not fall within those categories and 'it is difficult to conclude that a skilled lawyer in 1946 would reasonably have considered that the phrase might encompass such conduct in the future';[8]
- the provision of services related to euthanasia are not medical services because '[i]f you have reached, by definition, an end of what medical treatment can do, then that which you are doing is not medical treatment';[9] and
- as such, including the provision of services related to euthanasia within the scope of 'medical services' 'would represent a fundamental shift in the core meaning of that phrase rather than the enlargement of its radius to accommodate new factual developments'.[10]

3.11 It was recognised, however, that there was room for doubt in this conclusion, brought about by matters including that:

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2 *Submission 36*, attachment, p. 23.

3 *Submission 36*, attachment, p. 23.

4 *Submission 36*, attachment, pp. 23, 24.

5 *Submission 1*, pp. 4, 5; *Submission 36*, attachment, pp. 19-20; *Submission 53*, p. 3.

6 *Submission 36*, attachment, pp. 15-16, 17-19, 20-22, 24; *Submission 6*, p. 6.

7 *Submission 36*, attachment, p. 24. See also *Submission* 6, p. 6.

8 *Submission 36*, attachment, p. 24.

9 Mr John Bond QC, Catholic Health Australia, *Proof Committee Hansard*, 15 October 2014, p. 51.

10 *Submission 36*, attachment, p. 24. See also *Submission 1*, p. 5; and *Submission 53*, p. 3.

- there may be a range of views about what the phrase 'medical services' means[11] and, in any possible challenge in the High Court, it would not be for the Court to 'pass upon the wisdom or suitability of the particular scheme';[12]
- 'some words or concepts expressed in the Constitution, by their nature or expression, are given an ambulatory meaning so as necessarily to encompass later developments in a particular field' and the concept of 'medical services' could be considered to be of that type;[13]
- where there could be wide or narrow interpretations of a particular provision of the *Constitution*, the broader interpretation should be preferred 'unless there is something in the context or in the rest of the Constitution to indicate that the narrower interpretation will best carry out its object and purpose'.[14] The text of the *Constitution*, in other words, should be interpreted 'with all the generality which the words used admit';[15]
- the High Court has not 'grappled directly with the meaning of "medical services" or "pharmaceutical, sickness and hospital benefits" in circumstances which shed light on the present issue';[16]
- the High Court has, however, accepted that the meaning of 'medical service' is to be 'informed by [the] nature of that which is done by doctors in providing their professional services';[17] and
- it has been held that the scope of the power under subsection 51(xxiiiA) is not confined to that which is legal under State law.[18]

3.12 Drawing on a number of these matters, the Public Law and Policy Research Unit at the University of Adelaide concluded that a 'dying with dignity medical service' *is* a 'medical service' within the meaning of subsection 51(xxiiiA), arguing that the meaning of the phrase 'must be informed by the dynamic nature of the medical practice' and that, 'from a purely constitutional standpoint, there is no obvious

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11 *Submission 36*, attachment, p. 24.

12 *Submission 36*, attachment, p. 9, citing *Alexandra Private Geriatric Hospital Pty Ltd v Commonwealth* (1987) 162 CLR 271, 283.

13 *Submission 36*, attachment, pp. 11, 12, citing *Grain Pool (WA) v Commonwealth* (2000) 202 CLR 479.

14 *Submission 36*, attachment, p. 10, citing *Jumbunna Coal Mine NL v Victoria Coal Miners' Association* (1908) 6 CLR 309, 368.

15 *Submission 36*, attachment, p. 12 and *Submission 47*, p. 5, citing *Grain Pool (WA) v Commonwealth* (2000) 202 CLR 479, [16].

16 *Submission 36*, attachment, p. 8. See also *Submission 47*, pp. 3, 4.

17 *Submission 36*, attachment, p. 6, citing *Federal Council of the British Medical Association in Australia v Commonwealth* (1949) 79 CLR 201, 256, 287, 293.

18 *Submission 36*, attachment, pp. 6-7, 16, citing *Federal Council of the British Medical Association in Australia v Commonwealth* (1949) 79 CLR 201, 266.

inference to be drawn that the meaning of 'medical service' is solely limited to the preservation of life'.[19]

Meaning of 'pharmaceutical, sickness and hospital benefits'

3.13 The second question concerning the constitutionality of the Bill under the medical services power was whether or not 'dying with dignity medical services' are 'pharmaceutical, sickness and hospital benefits' within the meaning of subsection 51(xxiiiA) of the *Constitution*.[20]

3.14 Those who concluded that they are not argued, first, that 'dying with dignity medical services' are not 'hospital benefits' because they are not expressed to have any connexion with any hospital and could very well be performed outside hospitals, including within the patient's home.[21]

3.15 It was recognised, however, that the position was less clear in relation to sickness and pharmaceutical benefits.[22] Catholic Health Australia, for example, recognised that:

(i) the phrase 'benefits' is not limited to the grant of money and may include the provision of a service;[23]

(ii) sickness (specifically, terminal illness) is a condition precedent to the provision of a 'dying with dignity medical service';[24] and

(iii) the provision of a 'dying with dignity medical service' is likely to involve pharmaceutical compounds.[25]

3.16 Catholic Health Australia nonetheless argued that a 'dying with dignity medical service' was not a sickness or pharmaceutical benefit for four reasons:

(i) it is unlikely that the phrases 'sickness benefit' or 'pharmaceutical benefit' include services that were criminal in 1946 and which remain so today;[26]

(ii) the concept of benefit includes 'the notion that it will "relieve the person to whom it is provided from a cost which that person would otherwise incur"', but the Bill concerns a service that could otherwise not be provided and in respect of which no liability could

19 *Submission 47*, pp. 5–6.

20 *Submission 36*, attachment, pp. 24–26.

21 *Submission 36*, attachment, p. 25.

22 *Submission 36*, attachment, p. 25.

23 *Submission 36*, attachment, pp. 5, 9, 25, citing *Federal Council of the British Medical Association in Australia v Commonwealth* (1949) 79 CLR 201, 279 and *Alexandra Private Geriatric Hospital Pty Ltd v Commonwealth* (1987) 162 CLR 271 at 280.

24 *Submission 36*, attachment, p. 25.

25 *Submission 36*, attachment, p. 25.

26 *Submission 36*, attachment, p. 25.

otherwise be incurred. It therefore 'does not provide for the provision of material aid in the sense of provision of a service (or the payment for it) to relieve against its financial consequence';[27]

(iii) a sickness benefit within the meaning of subsection 51(xxiiiA) must be directed towards the consequence of being sick, but 'dying with dignity medical services' are not directed towards that consequence;[28] and

(iv) the definitions of 'benefit' used in the case law support 'the view that there must be a social services character to the legislation'. 'In circumstances where the common law, State law and the medical profession in Australia each rail against the service contemplated, it is difficult to see that it would be proper to view the provision (or payment) of that service of having a social services character'.[29]

3.17 On the other hand, the Public Law and Policy Research Unit at the University of Adelaide concluded that 'dying with dignity medical services' are 'arguably' sickness and hospital benefits. Having highlighted case law that defines 'benefit' in this context as 'the provision of aid to or for individuals for human wants arising as a consequence of…being sick',[30] they reasoned that:

> The individual is certainly 'sick' and seeking the services of a medical practitioner. There is scope for an argument that the provision of a service that results in death is not the provision of a benefit. However, we believe there is a strong argument that this would be found to be the provision of a material aid in the form of a service, designed, in the view of Parliament, to promote social welfare and security.[31]

3.18 They further noted that '[t]he interpretation of the head of power in this way highlights that the wisdom or otherwise of measures within this Bill are to be determined by Parliament'.[32]

Meaning of 'provision'

3.19 The High Court has often emphasised the importance of the word 'provision' in subsection 51(xxiiiA).[33] In particular, it should be noted that:

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27 *Submission 36*, attachment, pp. 25-26, citing *Williams v Commonwealth of Australia* [2014] HCA 23, [46].

28 *Submission 36*, attachment, p. 26, citing *Williams v Commonwealth of Australia* [2014] HCA 23, [46].

29 *Submission 36*, attachment, p. 26.

30 *Williams v Commonwealth of Australia* [2014] HCA 23, [46].

31 *Submission 47*, pp. 6–7. See also *Submission 87*, p. 7.

32 *Submission 47*, p. 7.

(a) the power is not a general power to make laws with respect to the matters listed in subsection 51(xxiiiA). It is a power to make laws with respect *to the provision of* such benefits and services;[34] and

(b) 'the provision of' benefits or services is to be understood as the provision of benefits or services *by the Commonwealth*;[35] but

(c) benefits and services do not need to be provided directly by the Commonwealth;[36] they may be provided, for example, by those in the private sector in return for a government subsidy;[37] and

(d) the Commonwealth may regulate the provision of benefits and services where this is incidental to their provision by the Commonwealth in order to ensure that the provision is 'effectively administered with due regard to the interests both of the intended recipient and the revenue'.[38]

3.20 The Public Law and Policy Research Unit at the University of Adelaide submitted that these requirements were satisfied by Part 3 of the Bill, which provides for the payment by the Commonwealth of the costs of 'dying with dignity medical services'.[39]

Meaning of 'civil conscription'

3.21 Subsection 51(xxiiiA) contains an express prohibition on the use of the medical services power 'to authorize any form of civil conscription'.

3.22 The submission of Catholic Health Australia provided a helpful description of the events that led to the inclusion of subsection 51(xxiiiA) in 1946,[40] which included the explanation that the prohibition on civil conscription was inserted to allay fears that 'the proposed amendment would grant the Commonwealth the power to nationalise medical and dental services'.[41]

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33 See, for example, *Federal Council of the British Medical Association in Australia v Commonwealth* (1949) 79 CLR 201, 260, 279; *General Practitioners Society of Australia v Commonwealth* (1980) 145 CLR 532, 557 and *Alexandra Private Geriatric Hospital Pty Ltd v Commonwealth* (1987) 162 CLR 271, 279.

34 *Federal Council of the British Medical Association in Australia v Commonwealth* (1949) 79 CLR 201, 242-243.

35 *Alexandra Private Geriatric Hospital Pty Ltd v Commonwealth* (1987) 162 CLR 271, 279; *Federal Council of the British Medical Association in Australia v Commonwealth* (1949) 79 CLR 201, 243, 254, 260, 279, 292.

36 *Federal Council of the British Medical Association in Australia v Commonwealth* (1949) 79 CLR 201, 260–261.

37 *Alexandra Private Geriatric Hospital Pty Ltd v Commonwealth* (1987) 162 CLR 271, 282.

38 *Alexandra Private Geriatric Hospital Pty Ltd v Commonwealth* (1987) 162 CLR 271, 281–284.

39 *Submission 47*, p. 4.

40 *Submission 36*, attachment, pp. 13–15.

41 *Submission 36*, attachment, p. 13.

3.23 The prohibition on civil conscription has been described as referring to:

> …any sort of compulsion to engage in practice as a doctor or a dentist or to perform particular medical or dental services. However, in its natural meaning it does not refer to compulsion to do, in a particular way, some act in the course of carrying on practice or performing a service, when there is no compulsion to carry on the practice or perform the service.[42]

3.24 Importantly, the prohibition on civil conscription only applies to the provision of 'medical and dental services' and not to the other elements of subsection 51(xxiiiA).[43]

The corporations power

3.25 Subsection 51(xx) of the *Constitution* provides as follows:

> The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to:
>
> …
>
> (xx) foreign corporations, and trading or financial corporations formed within the limits of the Commonwealth

3.26 As noted above, clause 7(2) of the Bill provides as follows:

> (2) This Act has, by force of this subsection, the effect it would have if its operation were, by express provision, confined to a medical practitioner employed by a constitutional corporation.

3.27 Clause 7(4) defines 'constitutional corporation' to mean 'a corporation to which paragraph 51(xx) of the Constitution applies'. Any foreign corporation or any Australian corporation that engages in substantial trading and financial activities will be considered a 'constitutional corporation'.[44]

3.28 The corporations power has been interpreted broadly in recent times by the High Court. In the so-called 'Work Choices Case', the majority held that the corporations power extended to any law which 'imposes a duty or liability, or confers a right or privilege, only on a constitutional corporation'.[45] The majority held that this included regulating the conduct of 'those through whom it acts', including employees.[46] More recently, the Court has emphasised that, to fall within the

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42 *General Practitioners Society in Australia v Commonwealth* (1980) 145 CLR 532, 557.

43 *Federal Council of the British Medical Association in Australia v Commonwealth* (1949) 79 CLR 201, 254-255, 261, 281-282, 286-287.

44 *R v Federal Court of Australia; Ex parte WA National Football League* (1979) 143 CLR 190; *State Superannuation Board of Victoria v Trade Practices Commission* (1982) 150 CLR 282; *Commonwealth v Tasmania* (1983) 158 CLR 1.

45 *Submission 36*, attachment, p. 27, citing *New South Wales v Commonwealth* (2006) 229 CLR 1, [181].

46 *Submission 36*, attachment, p. 27, citing *New South Wales v Commonwealth* (2006) 229 CLR 1, [181].

corporations power, the law needs to regulate or permit acts done by or on behalf of corporations.[47]

3.29 Catholic Health Australia argued that the Bill would not be supported by the corporations power if it applied only to medical practitioners employed by a constitutional corporation for four reasons, namely that:

(i) the Bill 'would still be directed to the conduct and activities of persons who are "medical practitioners" rather than the constitutional corporation who employed them'. Only medical practitioners (and not the constitutional corporations that employed them) would receive the benefit of the immunity; only medical practitioners would be taken to have entered into an agreement with the Commonwealth for the performance of the service; and only medical practitioners would have the right to claim payment. Furthermore, there would be no requirement even that the medical practitioner provide the service in the course of their employment by the constitutional corporation.[48]

(ii) there is no requirement in the Bill that the medical practitioner provide the service on behalf of the constitutional corporation;[49]

(iii) 'the mere fact that the subject of regulation by the Bill was an employee of a constitutional corporation [is not a] sufficient connection with the s. 51(xx) head of power to warrant a conclusion that the Bill was an exercise of power with respect to constitutional corporations. Some more substantial connection with the activities of the constitutional corporation which themselves were being regulated would be required';[50] and

(iv) the method of reimbursement envisaged in the Bill 'seems to us to [be] more consistent' with the reliance on the 'medical services' power.[51]

3.30 The Public Law and Policy Research Unit at the University of Adelaide appeared to agree with the thrust of these arguments, suggesting that the argument for validity under the corporations power would be strengthened if clause 7(2) were amended to read as follows:

> This Act has, by force of this subsection, the effect it would have if all references to a ‘medical practitioner’ were, by express provision, confined

47 *Williams v Commonwealth of Australia* [2014] HCA 23, [50].

48 *Submission 36*, attachment, pp. 27–28.

49 *Submission 36*, attachment, p. 28.

50 *Submission 36*, attachment, p. 29.

51 *Submission 36*, attachment, p. 29.

> to a medical practitioner employed by a constitutional corporation *acting in the course of their employment by that corporation*.[52]

3.31 At the public hearing conducted in Melbourne, Mr John Bond QC (who prepared the legal opinion that was attached to the submission of Catholic Health Australia), accepted that the amendment suggested by the Public Law and Policy Research Unit probably would improve the chances of the Bill surviving challenge on constitutional grounds.[53] He maintained, however, that—in his view—the Bill would still be unconstitutional, because:

> The bill is about saying: 'Medical practitioners can do this. Medical practitioners will be immune. Medical practitioners will be deemed to have entered into a contract with the Commonwealth for remuneration. Anyone else who seeks to induce them by the payment of money will be guilty of an offence.' That is all about medical practitioners; it is not about constitutional corporations.[54]

3.32 He further submitted that:

> …if the act was about medical practitioners acting in the course of their employment by that corporation then probably the constitutional corporation that employed them and paid them money to do it would be in breach of the prohibition against making inducements for the giving of this service.[55]

The territories power

3.33 Section 122 of the *Constitution* provides as follows:

> *Government of territories*
>
> The Parliament may make laws for the government of any territory surrendered by any State to and accepted by the Commonwealth, or of any territory placed by the Queen under the authority of and accepted by the Commonwealth, or otherwise acquired by the Commonwealth, and may allow the representation of such territory in either House of the Parliament to the extent and on the terms which it thinks fit.

3.34 Clause 7(3) of the Bill provides as follows:

> This Act has, by force of this subsection, the effect it would have if its operation were, by express provision, confined to a person engaging in conduct to the extent to which the conduct takes place wholly or partly in a Territory.

3.35 Catholic Health Australia accepted that, insofar as conduct occurring in a Territory is concerned, the Bill would be a valid exercise of the power conferred by

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52 *Submission 47*, pp. 7–8. See also *Submission 87*, p. 8.

53 John Bond QC, *Committee Hansard*, 15 October 2014, p. 50.

54 John Bond QC, *Committee Hansard*, 15 October 2014, p. 50.

55 John Bond QC, *Committee Hansard*, 15 October 2014, p. 50.

section 122 of the *Constitution*. It noted, in particular, that the territories power is 'unlimited and unqualified in point of subject matter'.[56] The Public Law and Policy Research Unit at the University of Adelaide concluded that the Bill could 'easily rely' on the territories power.[57]

Implied powers

3.36 Because neither the committee nor the submitters have had the benefit of an Explanatory Memorandum or similar document, they have had to deduce for themselves what the phrase 'implied legislative powers of the Commonwealth' in clause 6 means.

3.37 No submission considered that there was an applicable implied power upon which the Bill could rest.[58]

Consequences of invalidity

3.38 A key element of the Bill is to provide immunities to medical practitioners who provide 'dying with dignity medical services'. Specifically, where a person acts in good faith, for the purposes of the Bill and in accordance with the Bill, clause 24 provides an immunity from 'civil, criminal or disciplinary action' and clause 25 provides that such acts do not 'constitute an offence against a law of the Commonwealth, a State or a Territory'.

3.39 As noted by the submission of the Public Law and Policy Research Unit of the University of Adelaide, '[t]his requires the Bill to create an inconsistency with the relevant State legislation under s 109 of the Constitution, thus rendering the State laws inoperative'.[59] As the submission points out, there are very serious possible consequences for doctors who provide 'dying with dignity medical services' if the Bill is enacted but later found to be unconstitutional.[60] Such medical practitioners may find themselves facing homicide charges, despite the fact that they fully complied with the provisions of the Bill.

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56 *Submission 46*, attachment, p. 30, quoting *Teori Tau v Commonwealth* (1969) 119 CLR 564, 570.

57 *Submission 47*, p. 8.

58 *Submission 1*, pp. 5–6; *Submission 36*, attachment, p. 4.

59 *Submission 47*, pp 2, 9–10.

60 *Submission 47*, p 2.

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):
>
> - 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:
>
> > 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.
>
> The Australia and New Zealand Society of Palliative Medicine (ANZSPM) recognises:
>
> - 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.
>
> - 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:
>
> - 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

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.
>
> 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.
>
> 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.
>
> … 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.
>
> We would prefer 'illness' to be referred to within the bill as an 'Eligible medical condition'.
>
> The Tasmanian Voluntary Assisted Dying Bill 2013, for example, refers to an 'Eligible medical condition' and defines this as:
>
> Eligible medical condition

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 –
>
> (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
>
> (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.
>
> (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.
>
> …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.
>
> 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?
>
> 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

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.
>
> …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]

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.

Chapter 5

Committee comment and recommendation

5.1 The committee acknowledges and thanks the many thousands of people who, either through a representative organisation or as individuals, contributed to its inquiry. The level of engagement suggested to the committee that, although it was examining an exposure draft Bill rather than the broader policy issue of voluntary euthanasia, it is important that this very complex and emotive issue may be considered by the Parliament at some time in the future. Any debate needs to be undertaken in a sensitive, respectful and constructive manner and the committee is pleased to note that all who gave evidence to the committee did so in this mature way.

5.2 As mentioned, the Bill referred to the committee is an exposure draft prepared by an individual Senator. Therefore, as the Bill is not yet before the Senate, the committee is limited in the recommendations it can make.

5.3 Although the evidence received enabled the committee to consider some of the provisions of the Bill in detail, there remain some technical issues with a number of the provisions of the Bill. These include clarification of the definition of a dying with dignity service, clarification around the definition of a terminal illness, the number of medical practitioners required to consider the request, consistency of definition around decision-making capacity, and the serious consequences for medical practitioners who relied upon the immunities in the Bill if such immunities were later found to be unconstitutional.

5.4 The committee notes conflicting evidence it received in relation to the primary constitutional basis for the Bill under paragraph 51(xxiiiA). The committee was told that there could be very serious consequences for medical practitioners who relied upon the immunities in the Bill, if such immunities were later found to be unconstitutional. This concern is enlivened by the virtual certainty that any federal legislation dealing with voluntary euthanasia will face constitutional challenge.

Recommendation 1

5.5 The committee suggests that the proponent of the Exposure Draft of the Medical Services (Dying with Dignity) Bill 2014 might address the technical and other issues raised in evidence to the committee and seek the advice of relevant experts before the Bill is taken further.

Recommendation 2

5.6 The committee recommends that, if a Bill dealing with this broad policy issue is introduced in the Senate, Party Leaders should allow Senators a conscience vote.

Senator the Hon Ian Macdonald

Chair

Appendix 1

Public submissions

List of submissions

Sub No.	
1	Coalition for the Defence of Human Life
2	The Catholic Women's League of Australia Inc
3	South Australian Voluntary Euthanasia Society
4	Not Dead Yet UK
5	Dalby Christian Outreach Centre
6	Australian Family Association
7	Catholic Women’s League of Victoria & Wagga Wagga
8	Evangelicals for Life
9	Medical Oncology Group of Australia (MOGA)
10	Palliative Care Australia
11	Knights of the Southern Cross (WA) Inc.
12	9 concerned citizens
13	Dr Christopher Ryan
14	COTA Australia
15	Mr Alex Greenwich MP
16	Ms Rita Joseph
17	The Royal Australian and New Zealand College of Psychiatrists
18	Catholic Diocesan Centre
19	Salt Shakers
20	Dr Jeremy Prichard
21	Dying with Dignity NSW and Central Coast Group
22	The Australian and New Zealand Society of Palliative Medicine Inc.
23	Plunkett Centre for Ethics
24	Australian Medical Association's (AMA)
25	Catholic Archdiocese of Sydney
26	Australian Christians
27	Anglican Diocese of Sydney

Cabrini Health
South East Sydney LHD & St Vincent's Health Network
The Presbyterian Church of Tasmania
Ms Monica Doumit
Northern Territory Voluntary Euthanasia Society
Mr P McGavin
Organisation of Rabbis of Australisia
The Hon Katy Gallagher
Catholic Health Australia
Benetas
Health Care Consumer's Association of the ACT Inc
Lutheran Church of Australia
Family Voice
Australian Catholic Bishops Conference
Rationalist Society of Australia
Anglican Deaconess Ministries Limited
Institute for Judaism and Civilisation
Dying with Dignity Tasmania Inc
AFAO and NAPWHA
University of Adelaide
Australian Christian Lobby
ACT Right to Life Association
Prof Anthony Radford
The Royal Australian College of General Practitioners
The Right to Life Australia Inc.
Dr David Van Gend
Western Australian Voluntary Euthanasia Society (WAVES)
Pro-Life Victoria
Prof Margaret Otlowski
Australian College of Nursing
Dying with Dignity NSW
Christian Medical and Dental Fellowship of Australia
Australian Family Association WA
Voluntary Euthanasia Party NSW
Australian Sex Party

63 Confidential
64 Dying with Dignity Victoria
65 Western Australia Palliative Medicine Specialists Group
66 Euthanasia? NO! (A.C.T) Inc.
67 Dignitas
68 Palliative Care Nurses Australia Inc.
69 Atheist Foundation of Australia
70 Australian Psychological Society
71 Warialda Branch of Catholic Women's League
72 Ethical Rights
73 Australian Baptist Ministries
74 Co-Chairs of the Parliamentary Friends of Palliative Care (WA)
75 Alzheimer's Australia
76 Medicine with Morality
77 Wilberforce Foundation
78 Professor Roderick MacLeod and Associate Professor Andrew Cole
79 Humanist Society of WA
80 Liberty Victoria
81 Doctors for Voluntary Euthanasia
82 Australian and New Zealand Society for Geriatric Medicine
83 Doctors Opposed to Euthanasia
84 Dr Philip Nitschke, Exit International
85 Family Council of Victoria
86 Christians Supporting Choice for Voluntary Euthanasia
87 Dr Wendy Bonython and Bruce Arnold
88 Australian Nursing and Midwifery Federation (Victorian Branch)
89 Dying with Dignity ACT
90 National LGBTI Health Alliance
91 Minister Shane Rattenbury
92 Hon. Greg Donnelly
93 The Australian Jewish Community
94 Mr Peter Short
95 Ms Margaret Conyers
96 Dr David Faber
97 Mr Richard Davis

98 Dr Rosemary Jones
99 Dr Gordon McClatchie
100 Mr Clive Huxtable
101 Dr Malcom McKelvie
102 Mr Ron Hastings
103 Mr Chris Gavenlock
104 Mr Phil Browne
105 Ms Learne McMullan
106 Ms Stephanie Ryan
107 Mr Marshall Perron
108 Mr/Mrs Edward and Margaret Howse
109 Dr Richard Ammon
110 Mr Bill Alcock
111 Ms Maxine Godley
112 Ms Sue Currie
113 Mr Gerda Seaman
114 Mr Peter Hilton
115 Ms Joanna van Kool
116 Mr Morag Loh
117 Mr David Humrich
118 Ms Janine Truter
119 Mr Kanak Ranjay Ray
120 Ms Shayne Higson
121 Ms Loredana Alessio-Mulhall
122 Mr Kendall Lovett
123 Prof Rufus Clarke
124 Ms Deidre Johnson
125 Dr Julie Landvogt
126 Mr Nica Cordover
127 Ms Judith Hoy
128 Mr Stuart Carter
129 Mr Richard Mills
130 Dr Ronald Francis
131 Ms Lesley Cunningham
132 Mr Tom Hosking

133 Mr Rod Crisp
134 Mr Leon Holmes
135 Dr Noel and Betty Roberts
136 Mr Paul Clune
137 Sr Stancia Cawte
138 Dr Andrew Burke
139 Prof Gerald Fogarty
140 Ms Emma Wylde
141 Mr Patrick McNamara
142 Mr Roger Griffith
143 Mr David Ollerenshaw
144 Mr Jack and Nanette Blair
145 Mrs Patricia Gemmell
146 Mr Paul Ginnivan
147 Mr John Carroll
148 Mr James Gowing
149 Mr Tony Prince
150 Ms Bernadette Davies
151 Ms Ngaire McCrindle
152 Mr Rowan Shann
153 Mr Jesse Durdin
154 Mr Norman Banks
155 Mrs Glenda Furness
156 Mr Michael and Cecilia O'Connell
157 Mr Adrian Gunton
158 Dr Robert Claxton
159 Dr Brendan Triffett
160 Mr Michael Jensen
161 Dr Teem-Wing Yip
162 Mr Craig Southwell
163 Mrs Marilyn Colemon
164 Dr Voola Fourlanos
165 Lives Worth Living (LWL)
166 Mr Denis Strangman
167 Ms Allison McIntosh

168 Ms Babette Francis
169 Ms Sue Johnson
170 Ms Judith Rosewarne
171 Dr Margaret Graham
172 Dr John Obeid
173 Dr Jessica Stillwell
174 Mr Dennis Clarke
175 Mr Peter Phillips
176 Mr Jim McDonell
177 Mr Peter Murray
178 Dr Garry de Jager
179 The Catholic Women's League of Australia – New South Wales Inc.
180 Hope: preventing euthanasia & assisted suicide Inc.
181 Mr David Prichard
182 Mr Tom B Shorrock
183 Mr R G Clarke
184 Ms Barbara Harling
185 Mr Ray H Buttery OAM JP (rtd)
186 Mr Donald Casson
187 Mr Murray Hindle
188 Mr John Adam
189 Ms Ivy Bohmer
190 Ms Margaret Woods
191 Mr Richard W Stuckey
192 DyingForChoice.com
193 St Andrew's Presbyterian Church Naracoorte
194 Catholic Diocese of Wollongong
195 St Michael's Anglican Cathederal Wollongong
196 Australians Against Euthanasia
197 Tasmanian Baptist Churches
198 Mr Malcolm Auld
199 Name Withheld
200 Dr Geoff Sheahan
201 Miss Nicole Osmak
202 Name Withheld

203 Mrs Rosemarie Boneham
204 Miss Samantha Roberts
205 Ms Brigitta Van Strijp
206 John Wynter
207 Mr Paul McCormack
208 Dr Hayley Thomas
209 Name Withheld
210 Mrs Karina Ballast
211 Name Withheld
212 Name Withheld
213 Name Withheld
214 Name Withheld
215 Confidential
216 Mr Peter Dixon
217 Mr William Ditmarsch
218 Ms Jeanette Sheridan
219 Dr Ronda Jamieson
220 Mrs Lillian Elliott
221 Ms Jenni Bransgrove
222 Ms Marilyn Sunderland
223 Mr Paul Feldman
224 Mr Jon Cook
225 Ms Julie Ponder
226 Mr Richard Bickerton

Appendix 2

Public hearings and witnesses

Friday 3 October 2014—Canberra

ROOT, Ms Jo, National Policy Manager, COTA Australia

BOESEN, Mr Michael Thomas, Convenor, 9 Concerned Citizens

MARCH, Dr Milton Edgar, Member, 9 Concerned Citizens

RYAN, Dr Christopher, Private capacity

WALLACE, Mr Craig, Convenor, Lives Worth Living

BEST, Dr Megan, Office of the Archbishop, Anglican Church, Diocese of Sydney

FROMMER, Mr Michael David, Policy Analyst, Australian Federation of AIDS Organisations

LAKE, Mr Robert James, Executive Director, Australian Federation of AIDS Organisations

HIGSON, Ms Shayne, Christians Supporting Choice for Voluntary Euthanasia

WILLIAMS, Mr Geoffrey Kerr, Member, Christians Supporting Choice for Voluntary Euthanasia

BONYTHON, Dr Wendy, Private capacity

ARNOLD, Mr Bruce, Private capacity

SHELTON, Mr Lyle, Managing Director, Australian Christian Lobby

SIMON, Mr Daniel, Research Officer, Australian Christian Lobby

Wednesday 15 October 2014—Melbourne

McKAY, Dr Roderick, Chair, Community Consultative Committee, Royal Australian and New Zealand College of Psychiatrists

APPLEBY, Dr Gabrielle, Private Capacity

OLIJNYK, Ms Anna, Private Capacity

OTLOWSKI, Professor Margaret, Private Capacity

PRICHARD, Dr Jeremy, Private Capacity

KELLEHER, Mrs Terri, National President, Australian Family Association

PHILLIPS, Mrs Roslyn Helen, National Research Officer, FamilyVoice Australia

COLE, Associate Professor Andrew Malcolm Dermot, Chief Medical Officer, HammondCare

MacLEOD, Professor Roderick Duncan, Senior Staff Specialist and Conjoint Professor, HammondCare

SHORT, Mr Peter George, Private capacity

TOBIN, Dr Bernadette, Director, Plunkett Centre for Ethics

HINDLE, Mr Muray, Pesident, Western Australian Voluntary Euthanasia Society

MARR, Dr Robert, Co-convenor, Doctors for Voluntary Euthanasia

RAY, Mr Ranjan, Vice President, Western Australian Voluntary Euthanasia Society

VICK, Ms Lesley, Vice President, Dying with Dignity Victoria

WALKER, Mr Stephen, Committee Member, Western Australian Voluntary Euthanasia Society

WILLOUGHBY, Prof. John, Co-convenor, Doctors for Voluntary Euthanasia

BOND, Mr John, QC, Catholic Health Australia

DUNJEY, Dr Lachlan, Convenor, Medicine with Morality

GREENWOOD, Mrs Suzanne, Chief Executive Officer, Catholic Health Australia

KLEINIG, Dr Timothy, Chair, Doctors Opposed to Euthanasia

MICHAEL, Associate Professor Natasha, Director of Palliative Medicine, Cabrini Health, Catholic Health Australia

GRIDLEY, Ms Heather, Manager, Public Interest, Australian Psychological Society

McGRATH, Dr Helen, Member, Australian Psychological Society

STOKES, Mr David, Executive Manager, Professional Practice, Australian Psychological Society

ZIFCAK, Professor Spencer, Immediate past President, Liberty Victoria

APPENDIX 3

EXAMPLE OF PRO FORMA SUBMISSION QUESTIONS

1. Have you read items 8, 9 and 10 of the information at 'How to make a submission to a Senate Committee Inquiry'?
2. Have you read the Medical Services (Dying with Dignity) Exposure Draft Bill 2014?
3. Do you support the proposal in the Medical Services (Dying with Dignity) Exposure Draft Bill 2014?
4. Why/why not? (please limit response to 100 words)
5. Are you happy for your responses to be published?
6. Your name:
7. Your email address:

APPENDIX 4

ADDITIONAL INFORMATION

1. The right to choose an assisted death: Time for Legislation, report following a roundtable held by Australia21, provided by Emeritus Professor Bob Douglas AO
2. Additional Information provided by Christians Supporting Choice for Voluntary Euthanasia, received 3 October 2014 - I want the choice of a peaceful death
3. Additional Information provided by Christians Supporting Choice for Voluntary Euthanasia, received 3 October 2014
4. Additional Information provided by Christians Supporting Choice for Voluntary Euthanasia, received 3 October 2014
5. Additional Information provided by Christians Supporting Choice for Voluntary Euthanasia, received 3 October 2014
6. THE DOROTHEA SANDARS AND IRENE LEE CHURCHILL FELLOWSHIP to study the interface between Palliative Care and legalized Physician Assisted Suicide and Voluntary Euthanasia. Additional Information provided by Linda Sheahan, received 18 September 2014

ANSWERS TO QUESTIONS TAKEN ON NOTICE

1. RANZCP – answers to questions taken on notice at a public hearing on 15 October 2014 (received 24 October 2014)