Friday, 15 March 2013

Dear Premier Giddings

Catholic Women's League Australia Inc. (CWLA) is the national peak body representing the League's seven member organisations located throughout Australia, and including Tasmania.

We are a Non-Government Organisation and have consultative (Roster) status with the Economic and Social Council of the United Nations. We are also a member organisation of the World Union of Catholic Women's Organisations.

Our Research Centre, established in 2012, is based in Hobart, Tasmania.

Addressing social justice and ethical questions is one of our primary tasks. We seek to influence legislative and administrative bodies at all levels in order to preserve the dignity and rights of the human person. The subject matter of the current consultation is, therefore, of particular importance to our members and we welcome the opportunity to respond to the *Voluntary Assisted Dying: A proposal for Tasmania* (VAD).

SECTION A: GUIDING PRINCIPLES

The principle focus of the Catholic Church's interventions in the public arena is the protection and promotion of the dignity of the person. In this regard, the protection of human life in all its stages, from the first moment of conception until natural death is a non-negotiable principle. This principle is not, however, a 'truth of faith', but is 'inscribed in human nature' and therefore, common to all humanity.1

1 Benedict XVI, (March 2006). *Address to the members of the European People's Party*.

CWLA RESEARCH CENTRE
108 BATHURST STREET, HOBART, TASMANIA, 7000, AUSTRALIA
T: 0488 130 630 E: researchofficer@cwla.org.au W: www.cwla.org.au
ABN 91 323 005 375

Euthanasia is understood to be an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering. Euthanasia is distinguished from decisions to forego medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family. To forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death.[2]

Catholic teaching opposes euthanasia, even if its undertaking is genuinely voluntary, because it is the deliberate killing of another human being. Further to this principled objection, however, is our deep concern for the wider effects that the legalisation of euthanasia and assisted suicide would have upon vulnerable people, as well as the integrity and practice of health care and the law.

SECTION B: CWLA'S RESPONSE TO SPECIFIC SECTIONS OF VAD

In what follows, the original notation of VAD has been preserved for ease of reference.

2.1 Why 'voluntary assisted dying'?

The definition of 'voluntary assisted dying' replaces the definitions of euthanasia and assisted suicide used by The Joint Standing Committee on Community Development's 'Report on the Dying with Dignity Bill 2009.'

In the absence of any reasoning about why the term voluntary assisted dying is used in this paper, the Tasmanian public are left guessing as to why the authors have abandoned widely understood and accepted terms such as voluntary euthanasia and assisted suicide.

The abandonment of these terms creates the serious risk that members of the public may not comprehend the true nature of what is being proposed by VAD.

2 John Paul II.(1995) *Evangelium vitae*, 65.

If the intention behind the use of the term 'voluntary assisted dying' is to avoid negative stigma associated with the terms 'euthanasia' or 'assisted suicide,' this is dishonest and inappropriate for a community consultation.

2.2 Increasing support for voluntary assisted dying legislation

One of the principle and repeated arguments for the introduction of legal voluntary euthanasia and assisted suicide by VAD is that "community opinion in favour of voluntary assisted dying has increased steadily over the last 20 years and remains at a very high level."

Opinion polling in support of voluntary euthanasia and assisted suicide is given as evidence of this statement.

It has been demonstrated, however, that:

1. public opinion polls on euthanasia must be interpreted in the light of the wording of the question;
2. ignorance of the distinction between euthanasia and the withholding or withdrawal of treatment leads to support for euthanasia in public opinion poll questions; and
3. there is a significant relationship between opinions about the acceptability of euthanasia and inaccurate knowledge of the nature of euthanasia.[3]

As a result, it has been a worldwide phenomenon that *irrespective of opinion polling*, once politicians are reliably informed they almost always reject proposals for legalising voluntary euthanasia and assisted suicide due to concerns about public safety. Tasmania has been no exception.

The limitations of euthanasia polling were most recently observed in the state of Massachusetts where support for the legalisation of assisted suicide fell from 69% to 49% in just four weeks prior to the U.S. Election, once balanced information about the risks of the legislation were aired.

At any rate, the assumption that any practice with majority support in opinion polls should be legalised undermines the democratic notion that elected representatives act, in conscience, for the common good.

[3] Marcoux I, Mishara BL, Durand C. (2007) Confusion between euthanasia and other end-of-life decisions: influences on public opinion poll results. Can J Public Health. 98(3):235-9.

The Consultation Paper also extensively draws upon evidence presented in various reviews released in 2011 and 2012. These include that of the Royal Society of Canada, the Commission on Assisted Dying in the United Kingdom, the select committee report undertaken by the National Assembly of Québec and the judicial decision in Carter v. Canada.

CWLA notes, however, that each of these reviews has been subject to widespread criticism of bias.

The Canadian based and world renowned Australian ethicist, Professor Margaret Somerville, has described each of the Canadian reports as a 'pro-euthanasia' manifesto.[4]

Professor Sheila Baroness Hollins, the President of the British Medical Association stated that the report of the 2011 UK Commission on Assisted Dying "… is as much a propaganda exercise as a serious policy proposal, part of a concerted and determined campaign to normalise the idea of euthanasia."[5]

Carter v. Canada is presently under appeal by the Canadian government. The judgment has already been considered by the High Court of Ireland (Fleming v Ireland), with three High Court judges delivering a judgement (10 January 2013) which stated:

> ... the Canadian court reviewed the available evidence from other jurisdictions with liberalised legislation and concluded that there was no evidence of abuse. This court also reviewed the same evidence and has drawn exactly the opposite conclusions. The medical literature documents specific examples of abuse which, even if exceptional, are nonetheless deeply disturbing. Moreover, contrary to the views of the Canadian court, there is evidence from this literature that certain groups (such as disabled neonates and disabled or demented elderly persons) are vulnerable to abuse. Above all, the fact that the number of LAWER ("legally assisted deaths without explicit request") cases remains strikingly high in jurisdictions which have liberalised their law on assisted suicide (Switzerland, Netherlands and Belgium) – ranging from 0.4% to over 1% of all deaths in these jurisdictions according to the

[4] Retrieved from: http://www.mercatornet.com/articles/view/tipping_the_scales_towards_euthanasia
[5] Retrieved from: http://www.telegraph.co/uk/comment/telegraph-view/8995267/The-euthanasia-lobby-fails-to-make-its-case.html

latest figures – without any obvious official response speaks for itself as to the risks involved.[6]

2.3 Principles and values

The discussion paper describes the following 'principles and values' as underpinning the commitment to develop 'voluntary assisted dying' legislation:

- The value and importance of a tolerant democratic society and the rights and freedoms it provides for all of us when it comes to making decisions about matters involving our fundamental beliefs; and
- The importance of compassion for those who are nearing the end of their lives, particularly for those who have a medical condition that is going to shorten their lives and even more so if their medical condition is causing major suffering.

CWLA notes, however, that a 'tolerant democratic society' cannot exist without shared fundamental norms, foremost of which is the commitment to uphold the inviolability of human life.

Even if it were the case that 'a competent terminally ill patient seeking a quick painless death does not represent any harm to others in society and in the absence of such a threat the state does not have the right to subjugate the individual's autonomy' it does not follow that the state should facilitate this particular exercise of individual autonomy. The European Court of Human Rights and other commentators have concluded that even if individuals have the right to suicide, this does not necessarily entail that others – including the state – have an obligation to assist them. [7]

CWLA appreciates the compassionate motivation that lies behind the current proposal for legal voluntary euthanasia and assisted suicide. We note, however, that compassion literally means to 'suffer with' another human being. It is the resolve to genuinely invest yourself in people who are suffering; to offer the best assistance you can to relieve their physical and emotional anguish and to help them maintain hope and self esteem.

[6] 9 Kearns, P. *Fleming v. Ireland & Ors* 2013 IEHC 2 (Bailii)
[7] Prichard, Jeremy. (2012) Euthanasia: A reply to Bartels and Otlowski. *Journal of Law and Medicine.* 19: 620.

"True 'compassion' leads to sharing another's pain; it does not kill the person whose suffering we cannot bear."[8]

2.5 Current practices in end-of-life care

The dual claim that there are "clear indications" that in Australia (and elsewhere in jurisdictions that do not have specific voluntary assisted dying legislation) the law "has not prevented the practice of euthanasia or the intentional ending of life without the patient's consent" and that in Australia doctors are making "medical end-of-life decisions explicitly intended to hasten the patient's death without the patient's request" are based upon a single paper published in the *Medical Journal of Australia* over 15 years ago by Helga Kuhse, Peter Singer et al. [9]

This paper is repeatedly cited in VAD as evidence that doctors are already performing euthanasia and assisted suicide in Tasmania.

However VAD has ignored the fact this paper was the subject of significant methodological criticism by one of Australia pioneering palliative care physicians, Dr Brian Pollard, in the *Medical Journal of Australia*[10], as well as in the 1998 inquiry, and in submissions to the Senate on the Euthanasia Laws Bill in 1996.

Furthermore, in 2009 the Tasmanian branch of the Australian Medical Association provided an addendum to the Parliamentary Inquiry into the *Dying With Dignity Bill 2009* which stated:

> In conclusion, AMA Tasmania rejects Mr. McKim's assertion that euthanasia is a commonplace occurrence in Tasmania and reiterates its previously stated position that the proposed legislation is unnecessary and unsafe. AMA Tasmania contends that doctors should care for patients, not kill them.

[8] John Paul II (1995). *Evangelium vitae*, n.66.
[9] Helga Kuhse, Peter Singer, Peter Baume, Malcolm Clark and Maurice Rickard, 'End-of-life decisions in Australian medical practice', *The Medical Journal of Australia*, volume 166, number 4, (1997), pp. 191-196.
[10] Pollard, Brian. (1997) Letter. *Medical Journal of Australia.* Vol 166 pp 506-7.

The authors of VAD have chosen to overlook this evidence, focusing instead on anecdotal accounts given by witnesses to the 1998 Committee. In any case, if the example provided in the Discussion Paper of evidence from a former nurse to the 1998 Committee is any guide, it is likely that many of these accounts may not have even involved genuine acts of euthanasia:

> Whether admitted openly or not, practitioners constantly make decisions in care setting that end lives … Often without consultation, practitioners will decide who will be resuscitated, rehabilitated, given antibiotics or narcotics, and whose life machine will be turned off and at what time. (VAD, p. 41)

Practitioners who make such decisions can only be accused of performing euthanasia if they make 'decisions in care settings' that *intentionally* end lives. Decisions to withhold or withdraw medical treatment are commonly made on the basis that a treatment is, or has become, clinical futile or overly burdensome for a patient, but even where it is foreseen that death may be hastened as a result of such decisions this *is not* euthanasia. These decisions may occasionally be made without appropriate consultation with the patient, or where they are incapacitated, their next of kin. This is clearly not contemporary best practice, however it should be noted that this sort of benevolent paternalism was still fairly widely accepted within the dominant medical culture in 1998, and to infer that it was a malevolent expression of involuntary euthanasia is a gross misrepresentation of the truth.

3. THE CASE AGAINST VOLUNTARY ASSISTED DYING LAW REFORM

3.1 ISSUES

Contrary to the general expectations of the authors of VAD, the following comments on Section 3. are based upon information that is "reliable and valid", "up-to-date and as comprehensive as possible" and arguments which are "based on good quality information, as well as on reasonable assumptions and logical and well-considered conclusions".

3.2 ARGUMENTS AGAINST REFORM

VAD misrepresents and trivialises the **'sanctity of life' argument** as a 'religious viewpoint' which should not 'dominate the law or impinge upon the freedoms of others.' (p.20)

Yet while arguments that the legalisation of voluntary euthanasia and assisted suicide would undermine respect for the 'sanctity of human life' are often associated with religious belief, this is far from always the case.

Many non-religious people have a corresponding belief in the inviolability of human life, and firmly hold the view that there are no circumstances that can justify the deliberate and sanctioned taking of human life. Lying behind this belief is the sense that human life is not only instrumentally valuable for what it enables, but that it is *intrinsically valuable.*

While it is "also the case that, in the pluralistic and secular society in which we live, it is important that the beliefs of all individuals be respected and tolerated" (p.20) there must be some level of consensus about fundamental ethical principles. The inviolability of human life is one such principle. Without it, there is no justification for the punishment of homicide or manslaughter, and little justification for basic pursuits such as health care, including suicide prevention.

VAD's dismissal of 'slippery slope' arguments against the legalisation of voluntary euthanasia and assisted suicide is based upon a selective reading of the empirical research in this area.

VAD claims that the range of negative consequences , particularly for the most vulnerable in the community, foreseen by the 1998 Parliamentary Committee have not eventuated where legalised voluntary euthanasia and assisted suicide have been enacted. However, many, indeed the majority of the Parliamentary Committee's concerns have been in fact been realised.

A. The 1998 Committee was concerned that *the acceptance of voluntary euthanasia for the terminally ill would lead to acceptance of voluntary euthanasia for non-terminal conditions.*

Such 'bracket creep' has already occurred in the Netherlands. The 2011 report of the Region Euthanasia Review Committees shows the number of psychiatric patients who died as a result of euthanasia in the Netherlands has risen from 2 in 2010 to 13 in 2011. Euthanasia for people with dementia rose to 49. The Netherland's KNMG Physicians' Federation stated recently that "Contrary to what is generally assumed, the Euthanasia

Law includes provisions permitting assisted suicide for patients with psychiatric conditions and dementia."[11] Euthanasia is also now regarded as a legitimate option for elderly people who are 'tired of life,' with the KNMG believing that an accumulation of geriatric afflictions may also qualify as unbearable and lasting suffering within the meaning of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act. They state that: "Vulnerability – extending to such dimensions as loss of function, loneliness and loss of autonomy – should be part of the equation physicians use to assess requests for euthanasia." [12]

The European Institute of Bioethics (IEB), in Brussels, warned in 2012 that euthanasia in Belgium was being 'trivialised': "Initially legalized under very strict conditions, euthanasia has gradually become a very normal and even ordinary act to which patients are deemed "to have a right."[13] In recent weeks the media has reported the euthanasia deaths in Belgium of a woman who had been sexually abused by a well-known psychiatrist and of deaf twins who feared that they were going blind.

In the Netherlands, the Gronningen Protocol which has been approved by the medical and legal professions, allows for the termination of a child's life (under age 12)[14] The upper house of the Belgian parliament is also currently studying whether to extend the euthanasia to minors, boys and girls under the age of 18.

B. The 1998 Committee were *concerned that the acceptance of voluntary euthanasia will lead to involuntary euthanasia.* Today, documented evidence of euthanasia occurring without consent in jurisdictions where the practice has been legalised includes:

[11] KNMG Physicians Federation. (2011). *The role of the physician in the voluntary termination of life*, p.40)
[12] *Ibid.*
[13] E. de Diesbach, M. de Loze, C. Brochier and E. Montero. (2012). Euthanasia in Belgium: 10 years on. *Dossier of the European Institute of Bioethics*.
http://www.ieb-eib.org/fr/pdf/20121208-dossier-euthanasia-in-belgium-10-years.pdf
[14] Verhagen, E. and P. Sauer, P. (2005). The Groningen Protocol — Euthanasia in severely ill newborns. *The New England Journal of Medicine*, 352;(10)

I. In the Netherlands, the ending of life without an explicit patient request still occurs in 0·2 of deaths.[15]

II. 66 of 208 euthanasia deaths in the Flanders region of Belgium between June and November 2007 were without explicit request.[16] Another study of the practice of euthanasia in Flanders found that 45% of all euthanasia deaths, by nurses, were done without explicit request or consent.[17]

C. The Committee expressed concerns that:

- *The weaker members of society would be made more vulnerable through a diminishing of the value of human life and a subtle pressure would be brought to bear making the 'choice to die' a 'duty to die'; and*
- *Economic burdens both personal and social would encourage the euthanasia option for the weak and vulnerable;*

The Discussion Paper argues that the "evidence is not there to support the view that vulnerable people have been put at risk when voluntary assisted dying legislation has been introduced." In support of this position VAD cites a 2007 study by Battin *et al*. which, using data available in the annual reports on the operation of the Oregon and Dutch systems, could find no evidence that vulnerable groups of patients were over-represented in the statistics of patients who received an assisted death in those jurisdictions.

However, a major criticism of this study is that its analysis of the 2005 Netherland's report overlooks approximately 550 deaths which, because they occurred without request or consent, are not recorded as euthanasia cases. More generally, it also fails to account for the high level of *under reporting* of euthanasia that is documented by the 2005 Netherlands report. There is no way of knowing whether vulnerable people are over-represented among these patients who have received an assisted death, with or without their consent.

[15] Onwuteaka-Philipsen,B.D. et al. (2012) "Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey. " *The Lancet,* Published online July 11, 2012 http://dx.doi.org/10.1016/S0140-6736(12)61034-4.

[16] Kenneth Chambaere, Johan Bilsen et al. (2010) "Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey," *Canadian Medical Association Journal*. DOI:10.1503/cmaj.091876

[17] Inghelbrecht et al. (2010) "The role of nurses in physician-assisted deaths in Belgium," *Canadian Medical Association Journal*, 182(9): 905-10.

Furthermore, as the Tasmania legal academic, Jeremy Pritchard explains:

> Certainly measuring whether vulnerable groups are over-represented will help to detect macro-level abuse. Thus eg, if people from low socio-economic groups were over-represented in a legalised euthanasia system – whether in voluntary or non-voluntary contexts – it would suggest that some sort of systemic abuse was occurring. However, certain types of patient abuse are unlikely to be detected by quantitative analyses of this kind. One example of abuse involves pressuring patients to request access to voluntary euthanasia or physician-assisted suicide.[18]

So far as Pritchard can ascertain, only one qualitative study has investigated the issues of pressure on patients to access voluntary euthanasia or physician-assisted suicide. On this basis and against the backdrop of the growing literature on elder abuse, including risk factors, Pritchard writes:

> Taking these findings into account, it is perhaps optimistic of Bartels and Otlowski to assert that legalised voluntary euthanasia or physician-assisted suicide would protect Australian patients without considering what new risks it might raise. Such procedures may be safe for socially connected, financially independent individuals with high autonomy and self-efficacy…However, circumstances may be entirely different for isolated patients with low self-efficacy who represent an unwanted burden to their carers, some of whom may benefit financially from the death of the patient (even just in a reduction of financial pressure). Patients in such situations may conceivably meet eligibility criteria for voluntary euthanasia or physician-assisted suicide, including capacity to consent, having a terminal illness and lack of clinical depression. But their primary motivation for making such a request may be, eg, a feeling that it is the sensible option for all concerned; that their carers/family – well-intentioned or otherwise – have convinced them it is for the best; or that there are no other options.[19]

He later concludes:

> Arguably, eligibility safeguards for vulnerable elderly people will be of limited effectiveness insofar as pressure is concerned. Unless their psychological state is one of clinical depression (and this is detected by appropriate mental health

[18] Prichard, Jeremy. (2012) Euthanasia: A reply to Bartels and Otlowski. *Journal of Law and Medicine.* 19: 613.
[19] *ibid*, 616.

> professionals), elderly people who have been pressured to access voluntary euthanasia or physician-assisted suicide may nonetheless do so rationally and sincerely. If the elder abuse literature suggests that victims are disinclined to report their experiences for a variety of reasons, it seems plausible that patients who have been pressured to request this course may also be disinclined to disclose the actions of their relatives or carers. Could this same issue hamstring the deterrent effect of indictable offences relating to procuring through improper influence? This article suggests so. Failures to protect patients could affect public confidence in the criminal justice and health care systems.[20]

D. Other concerns of the 1998 Parliamentary Committee were that:

- *Suicide would become more prevalent in society as death is established as a 'quick fix' solution;*
- *Medical ethics and trust in doctors would diminish.*

Although causality has not been definitively established, the connection between rising suicides rates (which do not include deaths by physician assisted suicide) and the legalisation of physician assisted suicide in Oregon, USA, certainly deserves further scrutiny.

> The number of suicides in Oregon -- which has a suicide rate 35 percent higher than the national average -- keeps climbing. According to the state's violent death report, there were 566 suicides in 2008, 641 in 2009 and preliminary figures show 670 in 2010.[21]

A possible sign of the loosening of medical ethics in jurisdictions that have legalised voluntary euthanasia and/or assisted suicide, is that laws and regulatory 'safeguards' are commonly ignored.

---

[20] *ibid*, 620-1.

[21] http://www.oregonlive.com/portland/index.ssf/2011/10/alarming_increase_in_suicides.html

Half of all estimated cases of euthanasia in Flanders are not reported to the Federal Control and Evaluation Committee. [22] Although Belgium's law on euthanasia allows only physicians to perform the act, a 2007 study found that the life-ending drugs were administered by nurses in 12% of the cases of euthanasia and in 45% of the cases of assisted death without an explicit request from the patient ('non' or 'in'-voluntary euthanasia). In both types of assisted death, the nurses acted on the physician's orders but mostly in the physician's absence. [23]

Oregon's *Death With Dignity Act* requires physicians who believe that the judgment of a patient requesting assisted suicide is impaired by a psychiatric or psychological disorder (such as depression) to refer the patient for a psychological examination. Today, this rarely occurs. In 1998, the first year of the Oregon assisted suicide law, 11 of 24 people were sent for a psychiatric assessment. In 2010, only one of 65 people was referred for formal psychiatric or psychological evaluation. [24]

The Discussion Paper describes a third main argument against euthanasia and assisted suicide as follows: "it should never be a doctor's job to kill. His or her obligation is to cure, to palliate and to care, not to end a patient's life."

Rather than explore the rich and extensive body of work within the philosophy of medicine in support of this view, the Discussion Paper responds with the following:

> *Through our research we have noted that there are indications an increasing number of doctors accept that, in some circumstances, it is ethical and good professional practice to agree to a request from a patient for assistance to die.81*

Having reviewed Endnote 81, CWLA notes that the 'increasing number of doctors' referred to is *only* six.[25] At the same time, nowhere does VAD mention current position statements

[22] Tinne Smets, et al. (2010) "The Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases," *British Medical Journal*, 341:c5174.

[23] Inghelbrecht et al., "The role of nurses in physician-assisted deaths in Belgium," *Canadian Medical Association Journal*, June 15, 2010; 182(9); 905-10.

[24] 2010 Summary of Oregon's Death with Dignity Act.

[25] End note 81 states: "See for example the judicial decision in the case of Carter v Canada, paragraph 261".

against euthanasia by The World Medical Association [26] and the Australian Medical Association.[27]

Legally sanctioned medical killing would profoundly affect doctors both individually and as a profession. Doctors see themselves as the bringers of life, hope and healing, but once they intentionally kill patients, however well-meaningly, they would also be bringers of death. Because assisted suicide and euthanasia both involve doctors forming the judgment and acting upon the idea that some patients are better off dead, the ethical centre of the medical profession – its devotion to heal and refusal to kill – will be permanently destroyed and with it, patient trust.

3.3 CONCLUSION: WHAT DOES THE EVIDENCE SHOW?

It is of note that VAD affirms both Battin *et al*'s finding that "Those who received physician-assisted dying … appeared to enjoy comparative social, economic, educational, professional and other privileges" and the conclusion of the Commission on Assisted Dying that "…… it is usually the better educated, more articulate people who are able to access an assisted death." There is clear awareness, then, that the current proposal for 'voluntary assisted dying' is 'boutique legislation' for a distinct sector of the community only.

Again, the conclusions drawn in this section of the Paper overstate the weight of evidence in support of the safe legal regulation of euthanasia and assisted suicide, relying almost exclusive upon the findings of one paper, Battin et al, 'Legal physician-assisted dying in Oregon and the Netherland'.

Paragraph 261 of Carter v Canada reads: "In addition, the plaintiffs tendered the evidence of physicians from other countries who believe that assisting patients who wish to hasten death can be ethical: Dr. Ashby (Australia), Dr. Nancy Crumpacker (Oregon, U.S.A.), Dr. Kimsma (the Netherlands), Dr. Thomas Preston (Washington, U.S.A.), Dr. Peter Rasmussen (Oregon, U.S.A.); and Dr. Syme (Australia).

[26] http://www.wma.net/en/30publications/10policies/e13/

[27] https://ama.com.au/position-statement/role-medical-practitioner-end-life-care-2007

5. PROPOSAL FOR A TASMANIAN BILL

CWLA has no specific comments to make on the proposed model for voluntary euthanasia and assisted suicide. We have no interest in advising the Premier and the Leader of the Tasmanian Greens on the substance of legislation which we believe to be wholly against the interests of Tasmanians.

SECTION C: CONCLUDING REMARKS

CWLA is firmly of the view that:

1. The arguments presented in this Discussion Paper do not provide a compelling case for 'voluntary assisted dying law reform' in Tasmania.

2. There is insufficient evidence to support the view that a safeguarded voluntary euthanasia and assisted suicide law would not place vulnerable Tasmanians at risk or involuntary or coerced 'assisted dying'.

3. In line with overseas experience, if voluntary euthanasia and assisted suicide laws are enacted, with time the scope of their application is likely to extend beyond the group (e.g. individuals in the 'advanced stages of a terminal illness or condition) for whom the legislation was originally intended.

4. The long terms cultural effects of voluntary euthanasia and assisted suicide legislation are unknown. These could include negative societal attitudes towards people who are dying, elderly, chronically ill and disabled; damage to the moral integrity and morale of health care professionals; and a decline in respect for the inviolability of human life.

5. There is still considerable progress to be made before all Tasmanians have access to high quality palliative care. This should be a greater priority of government than the enacting of laws for voluntary euthanasia and assisted suicide which for the likely 'benefit' of the well-educated and articulate.

Authorised by: Jean R Tanzer O.A.M
National President, CWLA Inc.

Prepared by: (Dr) Brigid McKenna MBBS, M Bioethics
Research Officer
CWLA Research Centre
108 Bathurst St
Hobart TAS 7000
0488 130 630 | researchofficer@cwla.org.au