**LEGISLATIVE ASSEMBLY**
**FOR THE AUSTRALIAN CAPITAL TERRITORY**

SELECT COMMITTEE ON VOLUNTARY ASSISTED DYING BILL
Ms Suzanne Orr MLA (Chair), Ms Leanne Castley (Deputy Chair),
Mr Andrew Braddock MLA, Mr Ed Cocks MLA, Dr Marisa Paterson MLA

# Submission Cover Sheet

## Inquiry into the Voluntary Assisted Dying Bill 2023

**Submission Number:** 062

**Date Authorised for Publication:** 11 December 2023

# Submission on legal aspects of Voluntary Assisted Dying Bill 2023 (ACT)

Author: Hon Greg Smith SC, former NSW Attorney General and Minister for Justice 2011-2014

Under the current law, murder[1], (which includes euthanasia) and assisted suicide[2] are crimes. Prevention of suicide is lawful.[3]

---

[1] CRIMES ACT 1900 (ACT) - SECT 12 Murder
Murder

(1) A person commits murder if he or she causes the death of another person—

(a) intending to cause the death of any person; or

(b) with reckless indifference to the probability of causing the death of any person; or

(c) intending to cause serious harm to any person.

(2) A person who commits murder is guilty of an offence punishable, on conviction, by imprisonment for life.

(3) In this section:

"serious harm—"see the Criminal Code

, dictionary.

[2] CRIMES ACT 1900 (ACT) - SECT 17 Suicide—aiding etc

(1) A person who aids or abets the suicide or attempted suicide of another person is guilty of an offence punishable, on conviction, by imprisonment for 10 years.

(2) If—

(a) a person incites or counsels another person to commit suicide; and

(b) the other person commits, or attempts to commit, suicide as a consequence of that incitement or counselling;

the first-mentioned person is guilty of an offence punishable, on conviction, by imprisonment for 10 years.

3.CRIMES ACT 1900 (ACT) - SECT 18 Prevention of suicide

Prevention of suicide
It is lawful for a person to use the force that is reasonable to prevent the suicide of another person or any act that the person believes on reasonable grounds would, if committed, result in the suicide of another person.

**Court decisions upholding the illegality of Assisted Suicide**

The criminal laws especially of homicide of various nations have developed from the Common Law of the United Kingdom. In order to highlight the enormity of the proposed changes which the enactment of this Bill would entail, I propose to review some important decisions concerning euthanasia and assisted suicide, as well as some concerning the cessation of medical treatment, so as provide a background to attempts to legalise conduct which has been for centuries and remains currently illegal and unethical.

**United Kingdom**

**Pretty v UK (2002) 35 EHRR; R. (Pretty) v DPP [2001] UKHL 61, [2002] 1 AC 800.**

Diane Pretty died of natural causes on 11 May 2002 from motor neurone disease, a paralysing, degenerative and incurable illness. Her fight to choose the time and manner of her death assisted by her husband was a resounding legal failure. A unanimous body of judicial opinion in both the English Divisional Court and the House of Lords, followed by the European Court of Human Rights, denied that her rights under the European Convention on Human Rights had been infringed. Thus, the refusal of the Director of Public Prosecutions (DPP) to exempt Mrs. Pretty's husband from prosecution were he to undertake efforts to assist Mrs. Pretty in taking her own life was ultimately held to be lawful. At the same time, the domestic legal prohibition on assisting suicide, found in Section 2.1 of the Suicide Act of 1961 was found to be in conformity with the Convention.

In the course of his leading judgment in the House of Lords, Lord Bingham said at [9]:

“In the convention field the authority of domestic decisions is necessarily limited and, as already noted, Mrs Pretty bases her case on the convention. But it is worthy of note that her argument is inconsistent with two principles deeply embedded in English law. The first is a distinction between the taking of one's own life by one's own act and the taking of life through the intervention or with the help of a third party. The former has been permissible since suicide ceased to be a crime in 1961. The latter has continued to be proscribed. The distinction was very clearly expressed by Hoffmann LJ in Airedale NHS Trust v Bland [1993] AC 789 at 831. Bland was suffering from a persistent vegetative

state and hospital authorities wished to terminate his hydration and tube - feeding:

"No one in this case is suggesting that Anthony Bland should be given a lethal injection. But there is concern about ceasing to supply food as against, for example, ceasing to treat an infection with antibiotics. Is there any real distinction? In order to come to terms with our intuitive feelings about whether there is a distinction**, I must start by considering why most of us would be appalled if he was given a lethal injection. It is, I think, connected with our view that the sanctity of life entails its inviolability by an outsider. Subject to exceptions like self-defence, human life is inviolate even if the person in question has consented to its violation. (emphasis added)** That is why although suicide is not a crime, assisting someone to commit suicide is. It follows that, even if we think Anthony Bland would have consented, we would not be entitled to end his life by a lethal injection."

The second distinction is between the cessation of life-saving or life-prolonging treatment on the one hand and the taking of action lacking medical, therapeutic or palliative justification but intended solely to terminate life on the other. This distinction provided the rationale of the decisions in Bland. It was very succinctly expressed in the Court of Appeal in In re J (A Minor) (Wardship: Medical Treatment) [1991] Fam 33, in which Lord Donaldson of Lymington MR said, at p 46:

"What doctors and the court have to decide is whether, in the best interests of the child patient, a particular decision as to medical treatment should be taken which as a side effect will render death more or less likely. This is not a matter of semantics. It is fundamental. At the other end of the age spectrum, the use of drugs to reduce pain will often be fully justified, notwithstanding that this will hasten the moment of death. What can never be justified is the use of drugs or surgical procedures with the primary purpose of doing so."

Similar observations were made by Balcombe LJ at p 51 and Taylor LJ at p 53. While these distinctions are in no way binding on the European Court of Human Rights there is nothing to suggest that they are inconsistent with the jurisprudence which has grown up around the convention. It is not enough for Mrs Pretty to show that the United Kingdom would not be acting inconsistently with the convention if it were to permit assisted suicide; she must go further

and establish that the United Kingdom is in breach of the convention by failing to permit it or would be in breach of the convention if it did not permit it. Such a contention is in my opinion untenable, as the Divisional Court rightly held."

The words of Lord Hoffmann in Bland should be carefully considered by Members of Parliament considering this current Bill: " In order to come to terms with our intuitive feelings about whether there is a distinction, I must start by considering why most of us would be appalled if he was given a lethal injection. It is, I think, connected with our view that the sanctity of life entails its inviolability by an outsider. Subject to exceptions like self-defence, human life is inviolate even if the person in question has consented to its violation."

This Bill if enacted would fly in the face of these long-established principles of law.

**Australia**

In an important 1992 High Court of Australia decision, ***Department of Health & Community Services v JWB & SMB [1992] HCA 15; (1992) 175 CLR 218 (6 May 1992) known as Marion's Case,*** concerning Court permission to sterilise a 14 year-old disabled girl, Brennan J stated at [5] and [6]:

"As Blackstone wrote in his Commentaries (127) 17th ed. (1830), vol 3, p 120:

'the law cannot draw the line between different degrees of violence, and therefore totally prohibits the first and lowest stage of it; every man's person being sacred, and no other having a right to meddle with it, in any the slightest manner.' The effect is that everybody is protected not only against physical injury but against any form of physical molestation."

"6. Blackstone declared the right to personal security to be an absolute, or individual, right vested in each person by "the immutable laws of nature"(128) Blackstone, ibid., vol 1, pp 124, 129; vol 3, p 119. Blackstone's reason for the rule which forbids any form of molestation, namely, that "every man's person (is) sacred", points to the value which underlies and informs the law: each person has a unique dignity which the law respects and which it will protect.

Brennan J then stated in Marion's Case a most important principle:

6…. **"The law will protect equally the dignity of the hale and hearty and the dignity of the weak and lame; of the frail baby and of the frail aged; of the intellectually able and of the intellectually disabled." (emphasis added)**

And later continued:

8 “The law accepts that a person who is sui juris can consent to what would otherwise amount to an assault or trespass without impairment of dignity, although the interest of society in the physical integrity of its members precludes the law from giving effect to a consent to the doing of grievous harm”

**The United States of America**

1990. The US Supreme Court in ***Cruzan v Director, Missouri Department of Health (1990) 497 US 261*** ruled against an application by parents and guardians of Nancy Cruzan who was in a persistent vegetative state to terminate

her artificial nutrition and hydration, which would result in her death :

A short summary of the essential issues is:

Petitioner Nancy Cruzan is incompetent, having sustained severe injuries in an automobile accident, and now lies in a Missouri state hospital in what is referred to as a persistent vegetative state: generally, a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function. The State is bearing the cost of her care. Hospital employees refused, without court approval, to honor the request of Cruzan's parents, co-petitioners here, to terminate her artificial nutrition and hydration, since that would result in death. A state trial court authorized the termination, finding that a person in Cruzan's condition has a fundamental right under the State and Federal Constitutions to direct or refuse the withdrawal of death-prolonging procedures, and that Cruzan's expression to a former housemate that she would not wish to continue her life if sick or injured unless she could live at least halfway normally suggested that she would not wish to continue on with her nutrition and hydration.

The majority ruled:

1. The United States Constitution does not forbid Missouri to require that evidence of an incompetent's wishes as to the withdrawal of life-sustaining treatment be proved by clear and convincing evidence. Pp.520.

(a) Most state courts have based a right to refuse treatment on the common-law right to informed consent,

(b) A competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment. Cf., e.g., Jacobson v. Massachusetts, 197 U.S. 11, 2430. However, the question whether that constitutional right has been violated must be determined by balancing the liberty interest against relevant state interests. For purposes of this case, it is assumed that a competent person would have a constitutionally protected right to refuse lifesaving hydration and nutrition. This does not mean that an incompetent person should possess the same right, since such a person is unable to make an informed and voluntary choice to exercise that hypothetical right or any other right.

(c) It is permissible for Missouri, in its proceedings, to apply a clear and convincing evidence standard, which is an appropriate standard when the individual interests at stake are both particularly important and more substantial than mere loss of money, Santosky v. Kramer, 455 U.S. 745, 756. Here, Missouri has a general interest in the protection and preservation of human life, as well as other, more particular interests, at stake. It may legitimately seek to safeguard the personal element of an individual's choice between life and death. The State is also entitled to guard against potential abuses by surrogates who may not act to protect the patient.

2. The State Supreme Court did not commit constitutional error in concluding that the evidence adduced at trial did not amount to clear and convincing proof of Cruzan's desire to have hydration and nutrition withdrawn. The trial court had not adopted a clear and convincing evidence standard, and Cruzan's observations that she did not want to live life as a "vegetable" did not deal in terms with withdrawal of medical treatment or of hydration and nutrition. Pp.2021.

3. The Due Process Clause does not require a State to accept the "substituted judgment" of close family members in the absence of substantial proof that their views reflect the patient's.

Two later decisions of the US Supreme Court ruled that State prohibitions against assisting suicide were valid under the US Constitution. In ***WASHINGTON, et al., Petitioners, v. Harold GLUCKSBERG et al. (1997) 521 US 702.***

Delivering the majority judgment, Chief Justice Rehnquist commenced by stating:

Held: Washington's prohibition against "caus[ing]'' or "aid[ing]'' a suicide does not violate the Due Process Clause.

(a) An examination of our Nation's history, legal traditions, and practices demonstrates that Anglo-American common law has punished or otherwise disapproved of assisting suicide for over 700 years; that rendering such assistance is still a crime in almost every State; that such prohibitions have never contained exceptions for those who were near death; that the prohibitions have in recent years been reexamined and, for the most part, reaffirmed in a number of States; and that the President recently signed the Federal Assisted Suicide Funding Restriction Act of 1997, which prohibits the use of federal funds in support of physician-assisted suicide.

(b) In light of that history, this Court's decisions lead to the conclusion that respondents' asserted "right'' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause. The Court's established method of substantive-due-process analysis has two primary features: First, the Court has regularly observed that the Clause specially protects those fundamental rights and liberties which are, objectively, deeply rooted in this Nation's history and tradition.

Second, the Court has required a "careful description'' of the asserted fundamental liberty interest…..(citations removed) The Ninth Circuit's and respondents' various descriptions of the interest here at stake-e.g., a right to "determin[e] the time and manner of one's death,'' the "right to die,'' a "liberty to choose how to die,'' a right to "control of one's final days,'' "the right to choose a humane, dignified death,'' and "the liberty to shape death''-run counter to that second requirement. Since the Washington statute prohibits "aid[ing] another person to attempt suicide,'' the question before the Court is more properly characterized as whether the "liberty'' specially protected by the Clause includes a right to commit suicide which itself includes a right to assistance in doing so. This asserted right has no place in our Nation's traditions, given the country's consistent, almost universal, and continuing rejection of the right, even for terminally ill, mentally competent adults. To hold for respondents, the Court would have to reverse centuries of legal

doctrine and practice, and strike down the considered policy choice of almost every State. Respondents' contention that the asserted interest is consistent with this Court's substantive-due-process cases, if not with this Nation's history and practice, is unpersuasive. The constitutionally protected right to refuse lifesaving hydration and nutrition that was discussed in Cruzan, supra, at 279, 110 S.Ct., at 2851-2852, was not simply deduced from abstract concepts of personal autonomy, but was instead grounded in the Nation's history and traditions, given the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment. And although Casey recognized that many of the rights and liberties protected by the Due Process Clause sound in personal autonomy, (citations removed)….it does not follow that any and all important, intimate, and personal decisions are so protected, …(citations removed).

(c) The constitutional requirement that Washington's assisted-suicide ban be rationally related to legitimate government interests, see …(citations removed) is unquestionably met here. These interests include prohibiting intentional killing and preserving human life; preventing the serious public-health problem of suicide, especially among the young, the elderly, and those suffering from untreated pain or from depression or other mental disorders; protecting the medical profession's integrity and ethics and maintaining physicians' role as their patients' healers; protecting the poor, the elderly, disabled persons, the terminally ill, and persons in other vulnerable groups from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards voluntary and perhaps even involuntary euthanasia. The relative strengths of these various interests need not be weighed exactingly, since they are unquestionably important and legitimate, and the law at issue is at least reasonably related to their promotion and protection.

**Commentary on specific provisions of the ACT's VAD Bill**

8 Voluntary assisted dying not suicide

For the purposes of a territory law, and for the purposes of a contract, deed or other instrument entered into in the ACT or governed by a territory law, an individual who dies as the result of the administration of an approved substance by or to the individual in accordance with this Act—

(a) does not die by suicide; and

(b) is taken to have died from the condition mentioned in section 11 (1) (b).

This provision is inconsistent with Commonwealth law on the meaning of 'suicide', as used in ss 474.29A and 474.29B in the Criminal Code Act 1995 (Cth) as declared recently by Abraham J in ***Carr v Attorney-General (Cth) [2023] FCA 1500.*** If provisions similar to ss 19(1)(d)-(e), 28(1)(d)-(e) or 57(a) of the Victorian Voluntary Assisted Dying Act (2017) were inserted into the ACT VAD Bill then for the reasons set out in the judgment in Carr v Attorney-General (Cth), such provisions would be invalid.

It is noted that s.8 provides: '… an individual who dies as the result of the administration of an approved substance by or to the individual in accordance with this Act—

(a) does not die by suicide; and

(b) is taken to have died from the condition mentioned in section 11 (1) (b).'

**Conscientious objectors**

Individual medical practitioners may refuse first and subsequent requests to provide assistance to the person to die. See clause 94 below:

**Part 6 Conscientious objections—health practitioners and health service providers**

**94 Conscientious objection by health practitioner or health service provider**

(1) A health practitioner who has a conscientious objection to voluntary assisted dying may refuse to do any of the following:

(a) act as a coordinating practitioner, consulting practitioner or administering practitioner for an individual;

(b) provide advice to a coordinating practitioner in relation to a referral made under section 17 (Referral for advice about eligibility requirements);

(c) provide advice to a consulting practitioner in relation to a referral made under section 24 (Referral for advice about eligibility requirements);

(d) supply an approved substance;

(e) be present when an approved substance is administered by or to an individual.

(2) A health service provider who has a conscientious objection to voluntary assisted dying may refuse to do any of the following:

(a) participate in a request and assessment process;

(b) participate in an administration decision;

(c) be present when an approved substance is administered by or to an individual.

(3) In this section:

health service—see the Health Act 1993, section 5.

health service provider means a person who—

(a) is a health service provider for the Health Act 1993, section 7; or

(b) is prescribed by regulation as a health service provider.

Unlike some of the recently enacted State VAD Acts, hospitals and aged care facilities are not protected as "conscientious objectors" under the ACT Bill.

**The risk that the Bill if enacted in its present form could expose Catholic hospitals and aged care facilities to costly litigation and loss of funding is unacceptable and may lead these outstanding institutions being forced to close, thus depriving ACT citizens of excellent caring treatment.**

**Relevant Medical Condition**

10 When individual may access voluntary assisted dying

An individual may access voluntary assisted dying only if—

(a) the individual has made a first request; and

(b) the individual's coordinating practitioner has decided that the individual meets the eligibility requirements; and

(c) the individual's consulting practitioner has decided that the individual meets the eligibility requirements; and

(d) the individual has made a second request; and

(e) the individual has made a final request; and

(f) the individual's coordinating practitioner has decided that the individual meets the final assessment requirements; and

(g) the individual has made an administration decision; and

(h) if the individual has made a self administration decision—the individual's contact person appointment has taken effect.

11 Meaning of eligibility requirements

(1) For this Act, an individual meets the eligibility requirements if—

(a) they are an adult; and

(b) they have been diagnosed with a condition that, either on its own or in combination with 1 or more other diagnosed conditions, is advanced, progressive and expected to cause death (the relevant conditions); and

(c) they are suffering intolerably in relation to the relevant conditions; and

(d) they have decision-making capacity in relation to voluntary assisted dying; and

(e) their decision to access voluntary assisted dying is made voluntarily and without coercion; and

(f) they have—

(i) lived in the ACT for at least the previous 12 months; or

(ii) been granted an exemption under section 151.

(2) However, an individual does not meet the eligibility requirement mentioned in subsection (1) (b) only because they have a disability, mental disorder or mental illness.

(3) For subsection (1) (c), an individual is suffering intolerably in relation to their relevant conditions if—

(a) persistent suffering (whether physical, mental or both) is being caused to them by—

(i) 1 or more of the following matters:

(A) the relevant conditions;

(B) the combination of the relevant conditions and any other condition or conditions they have been diagnosed with (the other conditions);

(C) treatment they have received for the relevant conditions;

(D) the combination of treatments they have received for the relevant conditions and the other conditions; or

(ii) the anticipation or expectation, based on medical advice, of suffering that will or might be caused by a matter mentioned in subparagraph (i); or

(iii) a medical complication that will or might result from, or be related to, a matter mentioned in subparagraph (i); and

(b) the persistent suffering is, in their opinion, intolerable.

(4) In this section:

advanced—an individual's relevant conditions are advanced if—

(a) the individual's functioning and quality of life have declined; and

(b) any treatments that are available and acceptable to the individual lose any beneficial impact; and

(c) the individual is in the last stages of their life.

condition means a disease, illness or other medical condition.

disability—

(a) has the same meaning as it has in the Discrimination Act 1991, section 5AA (1); but

(b) does not include the meaning in that Act, section 5AA (2).

mental disorder—see the Mental Health Act 2015, section 9.

mental illness—see the Mental Health Act 2015, section 10.

progressive—an individual's condition is progressive if their condition is deteriorating and will continue to deteriorate.

12 Meaning of decision-making capacity

(1) For this Act, an individual has decision making capacity in relation to voluntary assisted dying if they can—

(a) understand the facts that relate to a decision about accessing voluntary assisted dying; and

(b) understand the main choices available to them in relation to the decision; and

(c) weigh up the consequences of the main choices; and

(d) understand how the consequences affect them; and

(e) on the basis of paragraphs (a) to (d), make the decision; and

(f) communicate the decision in whatever way they can.

(2) An individual must be assumed to have decision-making capacity in relation to voluntary assisted dying unless it is established that they do not have decision making capacity in relation to voluntary assisted dying.

(3) In deciding whether an individual has decision making capacity in relation to voluntary assisted dying, the following must be taken into account:

(a) an individual's decision-making capacity is particular to the decision they are to make;

(b) an individual is capable of making a decision if they are capable of making the decision with adequate and appropriate support;

(c) an individual must not be treated as not having decision making capacity unless all practicable steps to support them to make decisions have been taken;

(d) an individual must not be treated as not having decision making capacity only because they—

(i) make an unwise decision; or

(ii) have impaired decision making capacity under another Act, or in relation to another decision;

(e) an individual who moves between having and not having decision-making capacity must, if practicable, be given the opportunity to consider matters requiring a decision at a time when they have decision-making capacity.

## Difficulty in detecting coercion

People who are aged, frail and sick are sometimes taken advantage of by unscrupulous relatives, friends, even health practitioners. This is recognized by the following clauses of the Bill:

Section 7 (f) A person exercising a power or performing a

function under this Act must have regard to the following principles:

(f) there is a need to protect persons who may be subject to abuse or coercion;

Section 11 (1) For this Act, an individual meets the eligibility requirements if—

(e) their decision to access voluntary assisted dying is made voluntarily and without coercion;

Elderly frail and sick people sometimes feel guilty about continuing to live, particularly if they rely on younger family members to look after them. In a New Zealand piece by Jeremy Rees, “Assisted dying’s risk of coercion” published on the website, Newsroom, in July 2018, the author reviewed submissions made about David Seymour’s End of Life Choice Bill and commented:

“A long-time nurse, Bernadette Brocklebank, worries about the subtle pressure that can be placed on the old and ill. “I have been nursing for 38 years, and believe me people, the elderly in particular are without doubt coerced into making decisions by family and others who think they have nothing to offer society.”

“In their submission, the Anglican Bishops of Aotearoa/New Zealand, agree. They point to instances of elder abuse. “It is a well-established reality of our society and increasing year on year. Family members and care providers might bring subtle, or not so subtle, pressure to bear on an ageing family member to 'do the decent thing' and exit this life. We have known situations of such pressure driven by family members alarmed to see their inheritance evaporating with the costs of caring for an ageing parent….”

“The Royal College of Anaesthetists, too, highlights the subtle coercion that may be placed on a patient, in pain, confused and vulnerable. And it worries how a doctor can spot that coercion.”

The fact that "Coercion" is mentioned several times in the Bill, recognizes that the promoters of this Bill and those advising them are concerned that some patients requesting to be assisted to die may do so under coercion. Do doctors who are willing to assist have the ability to detect coercion? There is no requirement under the Bill that they have previously been a treating doctor of the patient and/or his/her family. The primary witness of coercion would be the patient and gathering evidence after that person's death would be most difficult.

**Decision Making Capacity**

The Australian Care Alliance has published details of a Study concerning decision making capacity of terminally ill patients.[4]In a landmark study of decision making capacity of persons with terminal cancer and a prognosis of less than six months to live – that is a cohort that would be eligible for assisted suicide under the schemes in Oregon and other US States as well as in Victoria, Australia – 90% were found to be impaired in regard to at least one of the four elements of decision making – Choice (15% impaired), Understanding (44%), Appreciation (49%) and Reasoning (85%).

Under Victoria's Voluntary Assisted Dying Act 2017, for example, "a person is presumed to have decision-making capacity unless there is evidence to the contrary" (Section 4(2)).

This study suggests that, at least in the case of persons with cancer and a prognosis of less than six months to live, it would be more prudent to start from the presumption that they are likely to have impaired decision making capacity unless it is demonstrated to the contrary.

The study also found a significant discrepancy between physician assessments of decision making capacity compared to the actual decision making capacity as tested on the MacCAT-T scales.

Physicians assessed as "unimpaired" 64% of those who, according to the MacCAT-T assessment had impaired Reasoning; 70% who had impaired

[4] https://www.australiancarealliance.org.au/1_lacking_capacity

Appreciation; 61% who had impaired Understanding and 100% of those who had impaired Choice.

This lack of ability of physicians who are actually caring for terminally ill cancer patients with a prognosis of less than six months to live to accurately assess their patients' decision making capacity is likely to be exceeded in flawed assessments of decision making capacity by other doctors – who do not necessarily have an established relationship with the person – making an assessment of decision making capacity in relation to a request for assisted suicide.

**Discussion**

The question of capacity is fundamental to a decision by a very ill person considering assistance in dying. Eminent medico-legal expert from Georgetown University, Professor John Keown has raised this issue, saying that "lawmakers and academics have in general failed adequately to point out the practical and ethical challenges embedded in the question when, and under what circumstances, a person has the capacity to choose and consent to VAE and PAS. "[5]

He refers to a considered analysis on this topic by Canadian Academic Louis C. Charland et al.,[6] who argued:

"There is a single issue that absolutely must be discussed when one considers the role of 'mental capacity' in consent to MAID. The issue in question is present in all cases of consent to MAID. But it is especially acute in cases that involve persons diagnosed with mental disorders. It can be summarized in one question that is rarely explored in sufficient detail but is very practical indeed: When, and under what circumstances, does a person seeking MAID have the mental capacity to decide to choose and consent to such a medical intervention? The question is absolutely fundamental since the decision-making capacity of an individual to consent to or refuse treatment is a pillar of our medical and legal system.

[5] John Keown-Euthanasia, Ethics and Public Policy An Argument Against Legalisation-Cambridge University Press-2nd Edition 2018, p.74

[6] 'Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders' (2016) *J Ethics Mental Health 1, 3*

Charland argues that Medical professionals, Politicians, academics and others "have in general failed to adequately point out the practical and ethical challenges embedded in this question. In particular, even the exceptions mentioned above do not discuss the detailed state of science in this area and its remaining limitations – which is the focus of the present discussion – even though they raise concerns about the problems of relying on capacity and informed consent to determine access to MAID. One could argue that the general public and law-makers have thus not been adequately educated and prepared for proper discussions on the challenges we will face, particularly when we rely on the concept of 'mental capacity' for more drastic life-ending interventions. Perhaps this is because the technical literature and current institutional practices that surround the assessment and determination of decision-making capacity, specifically, are so complex and specialized. Whatever the case may be, and while this obviously already raises questions about current end-of-life medical practices, the assessment of capacity as a tool for accessing life-ending interventions raises the stakes for all of us. Discussion is in order."

## Conclusion

The ACT Bill is heavily reliant on the Victorian Voluntary Assisted Dying Act 2017 and suffers from lack of critical analysis of its main provisions. It should be remembered that the original Bill was drafted by the Victorian Law Reform Commission on a reference from the Attorney General to draft a bill which would legalise euthanasia and assisted dying.

Professor John Keown made a critical examination of the several Committees involved in drafting the Victorian Bill[7]. After considering the deficiencies of the Parliamentary Committee Report, he referred to the Ministerial Advisory Panel on Voluntary Assisted Dying, which was then appointed to explore how best to implement the Parliamentary Committee's recommendation; it reported in July 2017. Though the members of both committees were doubtless well-intentioned, both reports were seriously flawed.

**The Panel's remit was not to consider whether but how the law should be relaxed. It was charged to advise the government "about how a**

[7] Keown, "Voluntary Assisted Dying in Australia: The Victorian Parliamentary Committee's Tenuous Case for Legalization", Issues in Law and Medicine, Volume 33, Number 1, 2018 p.55 at 56

**compassionate and safe legislative framework for voluntary assisted dying could be implemented." (emphasis added)**

Dr Keown was critical of the fact that the Parliamentary Committee's "Report stated that the summaries of the arguments were informed by four recent "investigations" into "assisted dying." First, why only these four? Why did the committee ignore the reports of the New York State Task Force on Life and the Law (the finest yet published); the House of Lords Select Committee on Medical Ethics, and the Scottish Health Committee. Second, why did the Parliamentary Report not consider whether, and the extent to which, the authors of the four "investigations" were supporters of legalization? One of the four was the UK Commission on Death and Dying, which was cited several times. The Parliamentary Report noted that this committee was chaired by Lord Falconer, funded by Sir Terry Pratchett and included a "broad range of experts." The Report omitted to inform the reader that Lord Falconer is the leading activist in the UK Parliament for PAS; that Sir Terry was a patron of the pressure-group "Dignity in Dying"; that nine of the twelve appointees were known to favor legalization and that many bodies, including the British Medical Association, declined to give evidence to this self-styled "Commission." Again, the Parliamentary Report noted that another of the four "investigations," by the Panel of the Royal Society of Canada, was produced by a group of academics but the Report omitted to mention that four of the six academics were internationally prominent advocates of legalization . If one's understanding of the ethical arguments is influenced by "investigations" dominated by those who are pro-legalization there is a risk that one will fail to appreciate the nature and force of the arguments against. The Report nowhere evinced an understanding of the key principled argument against legalization (and of the logical, and not only practical, implications of rejecting it), an argument to which we shall turn after we have criticized the Report's failure to articulate a clear and coherent case for legalization.

Dr Keown was critical of the Panel Report, which "stated that whereas deaths from suicide were avoidable and every effort should be made to prevent them, the people who were the focus of its report were facing an "inevitable, imminent death" as a result of an incurable illness or condition. (Id. at 8) But why shouldn't every effort be made to prevent their suicide? Was it because they were facing an "inevitable, imminent" death from illness? If so, many

people who kill themselves for all sorts of reasons – such as being old, lonely and neglected – have short life expectancies. And the Panel recommended that people with up to 12 months to live should be eligible for VE/PAS (id. at 13), even if they refused a treatment which could maintain their life beyond 12 months. (Id. at 67-68) In what sense is death 12 months or more away "imminent"?"

## Conclusion

It would be an ongoing disservice to the citizens of the ACT to enact this Bill without considering in detail the reasons for not allowing euthanasia and assisted suicide to become lawful.