Submission No 84

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Name: Mr Ashley Dewell et al.

Date Received: 22 November 2021

SUBMISSION

to the

New South Wales Legislative Council

Law and Justice Standing Committee Inquiry

into the provisions of the

Voluntary Assisted Dying Bill 2021 (NSW)

Introduction

1. On 14 October 2021, Mr Alex Greenwich MLA introduced the *Voluntary Assisted Dying Bill 2021* (NSW) ("**VAD Bill**"). In his second reading speech, Mr Greenwich stated that the VAD Bill intends to:[1]

> "*...create a safe framework for people who are in the final stages of a terminal illness and who are experiencing cruel suffering that cannot be relieved by treatment or palliative care to be provided with the choice to die peacefully, with dignity and surrounded by loved ones.*"

2. A further description of the purpose of the VAD Bill is found within its long title, specifically:[2]

> *An Act to provide for, and regulate access to, voluntary assisted dying for persons with a terminal illness; to establish the Voluntary Assisted Dying Board; and to make consequential amendments to other Acts.*

3. On 19 October 2021, the VAD Bill was referred to the Legislative Council Standing Committee on Law and Justice for inquiry and report by the first sitting day of 2022.[3]

4. This submission addresses the provisions of the VAD Bill, with reference to the underlying concept and to the likely specific consequences of its enactment, especially in light of international experience.

Dealing with Death

5. One of the few certainties in life is the inevitability of death, be it through illness, injury or the passage of time. Life expectancy may be increased by the combination of modern medicine, sanitation and the abundance of food, but the inevitability of death remains.

---

[1] Alex Greenwich MP, Second Reading speech, Voluntary Assisted Dying Bill 2021, *Hansard: Legislative Assembly* (New South Wales), 14 October 2021.
[2] *Voluntary Assisted Dying Bill 2021* (NSW), long title.
[3] https://www.parliament.nsw.gov.au/bills/Pages/bill-details.aspx?pk=3891

Every person must therefore, at some point, deal with the death of others around them, even as each of us draws ever closer to our own inevitable death.

6. Given the certainty of death, one possible response to a person who endures ongoing suffering, without the likelihood of recovery, is to hasten that inevitable death as a form of relief. Discussions regarding the legalisation of this action tend to involve the following terms.

(1) **Euthanasia**, which literally means "good death". The Australian Medical Association ("**AMA**") has defined this term as "*the act of deliberately ending the life of a patient for the purpose of ending intolerable pain and/or suffering*".[4] The Queensland Law Reform Commission[5] considered the terms 'passive euthanasia', where medical treatment is withheld or withdrawn, and 'active euthanasia', where medical intervention takes place to brin about death.[6] For the purpose of this submission, 'passive euthanasia' is not considered to be euthanasia at all, as it involves no deliberate action with the primary purpose of bringing about the death of a person.

(2) **Physician Assisted Suicide** ("**PAS**"), "*where the assistance of the doctor is intentionally directed at enabling an individual to end his or her own life*".[7]

(3) **Voluntary Assisted Dying** ("**VAD**"), which is the subject of the New South Wales VAD Bill and is described as a more accurate description of the circumstances.[8]

7. However, it is the substance of the action that is significant, rather than the label attributed to it. Considered in terms of substantive difference, there are only two relevant categories:

(1) A patient's refusal of ongoing life-sustaining or prolonging treatment, or a patient's acceptance of treatment primarily directed at pain relief which may have the incidental effect of shortening the maximum possible life span. This submission makes no objection to this practice and rejects any suggestion that such a practice constitutes any form of euthanasia, PAS or VAD.

(2) A deliberate action on the part of a healthcare professional to undertake action that is primarily intended to end the life of the patient. This might be labelled as euthanasia, PAS or VAD; but, for the purposes of this submission, the term VAD will be used to encompass the entirety of this practice.

---

[4] Australian Medical Association (AMA) position statement on euthanasia and assisted suicide, 22 November 2016, footnote 2, https://www.ama.com.au/sites/default/files/documents/AMA_Position_Statement_on_Euthanasia_and_Physician_Assisted_Suicide_2016.pdf

[5] 'A legal framework for voluntary assisted dying', Queensland Law Reform Commission, Report No 79, May 2021, https://www.qlrc.qld.gov.au/__data/assets/pdf_file/0020/681131/qlrc-report-79-a-legal-framework-for-voluntary-assisted-dying.pdf.

[6] 'Voluntary Assisted Dying Bill 2021 (NSW): A comparison with legislation in other states', NSW Parliamentary Research Service, No, 2, October 2021, p. 2.

[7] AMA position statement, 22 November 2016, *op. cit.*

[8] 'Voluntary Assisted Dying Bill 2021 (NSW), *op. cit.*

8. Supporters of VAD tend to assert that it is compassionate to relieve a person of ongoing suffering, even at the cost of that person's life, with the added benefit of preventing an affront to their dignity. Further, it is asserted that one's control over one's own life should extend to one's death, thus restoring a sense of control to those who have lost much of their autonomy by reason of illness. Finally, it is argued that laws prohibiting such practices do not work. Such an argument, however, presumes the justification of VAD, which relies upon supposed compassion and/or autonomy.

9. As will be set out below, the principles of compassion and autonomy are much more likely to be harmed than promoted by the passage of the VAD Bill.

The Value of Human Life

10. Despite the inevitability of death, human life holds inherent and unique value, which will be referred to as "**Absolute Value**".

Criminal Law

11. The Absolute Value of human life is demonstrated in NSW criminal law which punishes a) murder and manslaughter,[9] b) any assault that causes death,[10] c) acting with the intent to commit murder,[11] and d) conspiring to commit murder.[12] Further, Division 6 of Part 3 of the *Crimes Act 1900* (NSW) sets out a series of offences under the heading (emphasis added):

> "*Acts causing danger to life or bodily harm*"

12. The criminal law of NSW does not draw a distinction between the death of a person who is wealthy and a person who is poor. Nor is a distinction drawn between people based on their productivity, race, religion or any other characteristic. The commonality between people in vastly different circumstances is life itself, and it is the taking or endangerment of that life which is prohibited and punishable under NSW law.

Healthcare System

13. The Absolute Value of life is further demonstrated in the creation and funding of a system for the care of human health, in a manner not extended to any other form of life. The NSW Government assigned $30.2 billion to health care in the budget released on 22 June 2021, with the stated purpose of "*ensuring world-class health services for the community*".[13] Spending on health by the Commonwealth government in 2019-2020 reached $81.8 billion, being 16.3 % the Commonwealth government's total expenditure.[14]

---

[9] *Crimes Act 1900* (NSW), s 18.
[10] *Crimes Act 1900* (NSW), s 25A.
[11] See e.g., *Crimes Act 1900* (NSW), ss 27, 28.
[12] *Crimes Act 1900* (NSW), s 26.
[13] 'Record $30.2 billion for health care in NSW', 22 June 2021, NSW Department of Health, https://www.health.nsw.gov.au/news/Pages/20210622_04.aspx#:~:text=NSW%20Health%20has%20received%20%2430.2,and%20health%20facilities%20across%20NSW.
[14] Jennifer Phillips, Alex Grove and Lauren Cook, 'Budget Review 2019-20 Index for 'Health', https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201920/Health.

14. A person who enters the healthcare system should be confident that those who work within that system hold life to have Absolute Value. For example, promotional material for an Australian nursing course includes statements such as:[15]

> "*Nursing is all about the patient. It's a career that helps you save lives, bring happiness to individuals and their families, and comfort to those in need. ... While caring for patients fighting for their life can be a challenging experience, nurses still report a high level of job satisfaction.*"

15. This is not a new principle, for the earliest expression of medical ethics in the Western world, the Hippocratic Oath (from between the 5th and 3rd centuries BC) contained the following declaration:[16]

> *"I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan..."*

16. This principle finds expression in popular culture,[17] and in the version of the oath commonly administered in U.S. medical schools, which includes the following terms:

> *"Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God."*

17. The Absolute Value of life is also expressed in Australian professional codes:

    (1) "*Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively.*"[18]

    (2) "*In clinical practice, the care of your patient is your primary concern.*"[19]

Inevitability of Death

18. The Absolute Value of life does not deny the inevitability of death.

19. The *Good Medical Practice: a code of conduct for doctors in Australia*, issued by Australian Health Practitioner Regulation Agency, states:[20]

---

[15] 'Choose a career in nursing', Kangan Institute, Melbourne Docklands, TAFE Victoria, 20 November 2021, https://www.kangan.edu.au/students/blog/reasons-to-choose-nursing-as-a-profession.
[16] The Hippocratic Oath (*circa* 5th or 3rd centuries BC), https://www.nlm.nih.gov/hmd/greek/greek_oath.html
[17] E.g., the American science-fiction television series *Firefly*, season 1, episode 11 'Trash' (first broadcast June 28, 2003), in which Simon says to Jayne: "*You're in a dangerous line of work, Jayne. Odds are you'll be under my knife again, often. So I want you to understand one thing very clearly: No matter what you do or say or plot, no matter how you come down on us, I will never, ever harm you. You're on this table, you're safe ... 'cause I'm your medic.*"
[18] Medical Board of Australia, https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx, cl 2.1
[19] Ibid., cl 3.1
[20] Ibid.

"Doctors have a vital role in assisting the community to deal with the reality of death and its consequences. In caring for patients towards the end of their life, good medical practice involves:

...

4.13.3 Understanding the limits of medicine in prolonging life and recognising when efforts to prolong life may not benefit the patient.

4.13.4 Understanding that you do not have a duty to try to prolong life at all cost. However, you 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.

4.13.5 Accepting that patients have the right to refuse medical treatment or to request the withdrawal of treatment already started.

...

4.13.8 Encouraging advance care planning and facilitating the appropriate documentation, such as an advance care directive (or similar)."

20. Similarly, the Australian Medical Association's position statement on euthanasia and physician-assisted suicide states:[21]

"1.1 Doctors (medical practitioners) have an ethical duty to care for dying patients so that death is allowed to occur in comfort and with dignity.

1.2 Doctors should understand that they have a responsibility to initiate and provide good quality end of life care which:

- *strives to ensure that a dying patient is free from pain and suffering; and*
- *endeavours to uphold the patient's values, preferences and goals of care*

1.3 For most patients at the end of life, pain and other causes of suffering can be alleviated through the provision of good quality end of life care, including palliative care that focuses on symptom relief, the prevention of suffering and improvement of quality of life. There are some instances where it is difficult to achieve satisfactory relief of suffering.

1.4 All dying patients have the right to receive relief from pain and suffering, even where this may shorten their life.

1.5 Access to timely, good quality end of life and palliative care can vary throughout Australia. As a society, we must ensure that no individual requests euthanasia or physician-assisted suicide simply because they are unable to access this care.

---

[21] AMA position statement, 22 November 2016, *op. cit.*

1.6 As a matter of the highest priority, governments should strive to improve end of life care for all Australians through:

• the adequate resourcing of palliative care services and advance care planning;

• the development of clear and nationally consistent legislation protecting doctors in providing good end of life care; and

• increased development of, and adequate resourcing of, enhanced palliative care services, supporting general practitioners, other specialists, nursing staff and carers in providing end of life care to patients across Australia."

21. On 28 October 2017, the Australian Medical Association issued a further clarification on euthanasia and PAS which included the following:[22]

> "*The AMA's Position Statement is largely in line with the* [World Medical Association] *policy in stated that 'doctors should not be involved in interventions that have as their primary intention the ending of a person's life'.*"

22. As set out in paragraph 6(1), the Queensland Law Reform Commission adopted the term 'passive euthanasia', which involves the withdrawal of medical treatment.[23] A person can refuse medical treatment, even where that refusal will result in death, because interference with a person's body without that person's consent is prohibited by law.

23. Expressed in another way, the principle of inviolability of life permits the withholding and withdrawing of life-prolonging treatment that is not worthwhile because it is futile or excessively burdensome to the patient.[24] This is not to say that the patient's life is worthless, but rather that the treatment is worthless and allows for withdrawal of the worthless treatment notwithstanding that death is the foreseeable consequence.[25]

24. As set out above, this submission does not consider such a practice to be VAD, and a sharp distinction must be drawn between the cessation of resistance to death, and positive action intended to bring about death. Alex Schadenberg, executive director of the Euthanasia Prevention Coalition in Canada, notes that this distinction has also featured in euthanasia debates in his country:[26]

> "*When you actually question people, a lot say, 'Well, actually, I'm in favour of pulling the plug'; but pulling the plug is not actually euthanasia. Euthanasia is*

---

[22] Australian Medical Association (AMA) media release 'Euthanasia and physician-assisted suicide', 28 October 2017, https://www.ama.com.au/media/euthanasia-and-physician-assisted-suicide.

[23] 'A legal framework for voluntary assisted dying', Queensland Law Reform Commission, Report No 79, May 2021, https://www.qlrc.qld.gov.au/__data/assets/pdf_file/0020/681131/qlrc-report-79-a-legal-framework-for-voluntary-assisted-dying.pdf.

[24] Rob Heywood and Alexandra Mullock, 'The value of life in English law: revered but not sacred?', *Legal Studies*, Vol. 36, No. 4, 2016, p. 661.

[25] Ibid.

[26] Alex Schadenberg, with Paul Russell, 'How the euthanasia push was defeated in Canada', *News Weekly* (Australia), 30 October 2010, p. 12. https://ncc.org.au/uncategorized/4458-euthanasia-i-how-the-euthanasia-push-was-defeated/

directly and intentionally causing someone's death; that's what it's about – it's usually done by lethal injection."

25. Nor does the Australian Medical Association consider such practices to constitute VAD.[27]

> "*3.1 The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of treatments that are of no medical benefit to a dying patient.*"

26. The House of Lords Select Committee on Medical Ethics in 1994 considered the question of euthanasia and came to an unexpectedly unanimous rejection of the practice.[28] Speaking to the conclusions of the committee in his capacity as chair, British neuroscientist John (Lord) Walton upheld the right of a mentally competent patient to refuse medical treatment where the result is death, and stating:[29]

> "... *we defined voluntary euthanasia, at the request of the individual concerned, as being a deliberate intervention undertaken with the intention of ending a life so as to relieve intractable suffering; an act which must inevitably terminate life. We were unanimous in concluding that the right to refuse medical treatment is far removed from the right to request assistance in dying.*"

27. The recognition and acceptance of a patient's autonomy and right to refuse external measures that would have the effect of prolonging life:

    (1) remains completely distinct from VAD, because the latter involves a positive action taken with the intent to bring about the end of life; and

    (2) does not diminish the Absolute Value of life.

The Value of Life Despite the Inevitability of Death

28. Maintenance of the Absolute Value of life, even when a person can refuse life-sustaining treatment, is demonstrated in the practical presumption that treatment should be maintained.

29. Any decision to withdraw treatment, especially when that treatment will likely result in death, requires a clear expression of legal authority, such as by way of a properly executed Form of Enduing Guardianship under the *Guardianship Act 1987* (NSW). Such a document can only be properly executed when the person appointing the guardian has been informed of the legal consequences of the appointment, and when the Enduring Guardian has received similar advice regarding their appointment.[30]

---

[27] AMA position statement, 22 November 2016, *op. cit.*
[28] *House of Lords: Hansard* (Westminster, UK), Vol. 554, 9 May 1994, debate on report of the Select Committee on Medical Ethics (HL Paper 21), https://api.parliament.uk/historic-hansard/lords/1994/may/09/medical-ethics-select-committee-report
[29] (Lord) John Walton in House of Lords debate on medical ethics findings, *op. cit.*
[30] *Guardianship Act 1987* (NSW), s 6C.

30. Legislative declaration of the Absolute Value of life is also found in section 139C(c) of Schedule 1 to the *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW), which states (emphasis in original):

> "*Additional matters that constitute unsatisfactory professional conduct of medical practitioners [NSW]: In addition to the matters referred to in section 139B, '**unsatisfactory professional conduct**' of a medical practitioner also includes each of the following–*
>
> ...
>
> *(c) Refusing or failing, without reasonable cause, to attend (within a reasonable time after being requested to do so) on a person for the purpose of rendering professional services in the capacity of a medical practitioner if the practitioner has reasonable cause to believe the person is in need of urgent attention by a medical practitioner, unless the practitioner has taken all reasonable steps to ensure that another medical practitioner attends instead within a reasonable time.*"

31. By way of international example, in *W v M*, the court considered a person who was minimally conscious and lacked any binding advance decision to refuse life-sustaining treatment.[31] The court concluded that third party evidence of the person's probable wishes was not sufficient to withdraw treatment.[32] This judgment recognised that a minimally conscious person can experience life, whatever that might mean for the particular person.[33]

32. Lord Walton described his Select Committee's conclusions as follows:[34]

> "*Ultimately, however, we concluded that such arguments are not sufficient reason to weaken society's prohibition of intentional killing which is the cornerstone of law and of social relationships. Individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions. The issue of euthanasia is one in which the interests of the individual cannot be separated from those of society as a whole.*"

and later

> "*We considered carefully the question as to whether a new offence of mercy killing should be introduced into the criminal law. ... However, we concluded that to distinguish between murder and mercy killing would be to cross the line which prohibits any intentional killing, a line which we think is essential to preserve.*"

33. In summary, criminal law and healthcare are constructed around the fundamental foundation that life has Absolute Value, regardless of circumstances.

---

[31] *W v M* [2011] EWHC 2443 (Fam).
[32] *W v M* [2011] EWHC 2443 (Fam).
[33] *W v M* [2011] EWHC 2443 (Fam).
[34] Walton, *op. cit.*

Diminishing the Absolute Value of Human Life

Conceptual Change

34. Whatever might be asserted regarding compassion and autonomy, the legalisation of VAD would undermine the Absolute Value of life. As the Absolute Value of life rests at the centre of the healthcare system, any change to that value necessarily represents a substantial change to that system. Specifically:

    (1) At present, law and healthcare is constructed around the fundamental foundation that life has an Absolute Value, regardless of circumstances.

    (2) It is impossible to accept VAD without also accepting that the value of life has become conditional upon the circumstances of each person ("**Conditional Value**").

35. The adoption of VAD therefore represents a conceptual change to:

    (1) reject the Absolute Value of life; and

    (2) replace it with the Conditional Value of life.

36. This replacement directly contradicts the very first principle of the VAD Bill, that 'every human life has equal value'.[35] It is impossible to assert that every human life has equal value when creating a legal regime to end life based on the assessment of the conditions applicable to individual people, or Conditional Value.

37. Addressing the then proposed Victorian VAD legislation in 2017, former Australian Prime Minister Mr Paul Keating expressed the principle as follows:[36]

> "*Under this bill, conditions and safeguards are outlined that will allow physicians to terminate the life of patients and to assist patients to take their own life. This is a threshold moment for the country. No matter what justifications are offered for the bill, it constitutes an unacceptable departure in our approach to human existence and the irrevocable sanctity that should govern our understanding of what it means to be human.*"

and in relation to safeguards:

> "*No law and no process can achieve that objective. This is the point. If there are doctors prepared to bend the rules now, there will be doctors prepared to bend the rules under the new system. Beyond that, once termination of life is authorised the threshold is crossed. From that point it is much easier to liberalise the conditions governing the law. And liberalised they will be. Few people familiar with our politics would doubt that pressure would mount for further liberalisation based on the demand that people are being discriminated against if denied. The*

---

[35] *Voluntary Assisted Dying Bill 2021* (NSW), cl 4(1)(a).

[36] Paul Keating, 'Voluntary euthanasia is a threshold moment for Australia, and one we should not cross', *The Age* (Melbourne) 19 October 2017, https://www.theage.com.au/opinion/paul-keating-voluntary-euthanasia-is-a-threshold-moment-for-australia-and-one-we-should-not-cross-20171019-gz412h.html

experience of overseas jurisdictions suggests the pressures for further liberalisation are irresistible."

38. Rather, the rejection of Absolute value in favour of Conditional Value creates a situation expressed in 2017 by current NSW Premier (then state Treasurer) Mr Dominic Perrottet (emphasis added):[37]

> "*It's a dark, stark dissonance, and a confronting illustration of former prime minister Paul Keating's observation that, if we make assisted suicide legal, 'there will be people whose lives we honour and* ***those we believe are better off dead****'...*"

The VAD Bill

Intended Operation

39. The VAD Bill proposes to enable persons with a terminal illness to access voluntary assisted dying, and to provide procedures, regulations and a Voluntary Assisted Dying Board.[38] Access to this scheme is intended to be restricted to mentally competent adults who are Australian citizens living in NSW for at least one year,[39] and who satisfy the following criteria:

(1) The person has been diagnosed with at least one disease, illness or medical condition that is advanced, progressive, causes suffering that cannot be relieved in a way considered by the person to be tolerable and will likely cause death:

(a) within six months; or

(b) within 12 months in the case of a neurodegenerative disease.[40]

(2) The person is acting voluntarily in the absence of duress.[41]

(3) The person presents an enduring request.[42]

(4) The person's eligibility has been assessed by two medical practitioners.[43]

(5) If there is difficulty in determining whether the person has mental capacity, or is acting voluntarily, there is a provision for further assistance in the decision-making process.[44]

---

[37] Dominic Perrottet, 'Only one certainty if we make assisted suicide legal', *Sydney Morning Herald*, 1 November 2017, https://www.smh.com.au/opinion/only-one-certainty-if-we-make-assisted-suicide-legal-20171101-gzchpn.html

[38] 'Voluntary Assisted Dying Bill 2021 (NSW): A comparison ...', *op. cit.*, p. 3.

[39] *Voluntary Assisted Dying Bill 2021* (NSW), cl 16(1)(a)-(c), (e).

[40] Ibid, cl 16(1)(d).

[41] Ibid, cl 16(1)(f), (g).

[42] Ibid, cl 16(1)(h).

[43] Ibid, cl 25–31, 36–42.

[44] Ibid, cl 26, 27, 37, 38.

40. The VAD Bill purports to include safeguards that limit the possibility of abuse, including:

(1) Excluding patients from eligibility for VAD where it is sought solely because the patient has a disability or a mental health impairment.[45]

(2) Prohibition on healthcare workers discussing VAD with a patient unless they are providing information about all options, including palliative care.[46]

(3) A person must wait at least five days, and probably longer, to access VAD,[47] after which they can be killed.

(4) The person must be given information about their diagnosis and prognosis, palliative care and treatment options and the risks of taking a VAD substance,[48] such as side effects causing additional suffering without causing death, and, presumably, death itself.

(5) A person may change their decision about VAD at any time.[49]

(6) Contravention of these provisions by health practitioners may constitute unsatisfactory professional conduct or professional misconduct.[50]

(7) Offence provisions.[51]

Terminal Illness

41. The implementation of the criteria described above is intended to limit the availability of VAD. However, the very legalisation of VAD changes the fundamental presumption in healthcare from the Absolute Value of life to the Conditional Value of life, which shifts the value of a human being to an assessment of the conditions applicable to their life.

42. When life is assessed in the context of the Conditional Value, the follow propositions necessarily follow:[52]

(1) Protective guidelines (rather than a healthcare system built upon the foundation of the Absolute Value of life) will prevent abuse.

(2) Protective guidelines are an obstacle to overcome, in order to act compassionately towards, and to uphold the autonomy of, suffering people. For example, Australian euthanasia campaigner Dr Philip Nitschke reported that the four patients who took advantage of the brief period of legal euthanasia in the Northern

---

[45] Ibid, c 16(2).
[46] Ibid, cl 10.
[47] 'Voluntary Assisted Dying Bill 2021 (NSW): A comparison ...', *op. cit.*, p. 5.
[48] Ibid., p. 5.
[49] *Voluntary Assisted Dying Bill 2021* (NSW), cl 20, 54.
[50] Ibid., cl 11.
[51] Ibid., Part 7.
[52] Wesley J. Smith, 'Canada poised to legalize euthanasia for disabled and mentally ill' *National Review* (New York) 13 March 2021, www.nationalreview.com/corner/canada-poised-to-legalize-euthanasia-for-disabled-and-mentally-ill/.

Territory (from July 1996 to March 1997) saw psychiatric assessment as a step to be overcome.[53]

(3) Protective guidelines are removed, allowing for death on demand for any reason. This is the position in Germany.[54]

43. In Canada, a positive right to euthanasia was imposed by the courts in 2015, and the Parliament enacted a limitation that death must be 'reasonably foreseeable' for a person to qualify for a lethal injection.[55] Given the inevitably of eventual death, that restriction amounted to very little protection. Even so, by March 2021, a bill passed the House of Commons to remove the requirement for the 'reasonable foreseeability of death' as a precondition to VAD, opening the door to euthanasia of people such as those with disabilities and the mentally ill whose lives are not, otherwise, in danger.[56] A period of delay was also removed and, after some time for further study, people whose only condition is mental illness will qualify for euthanasia.[57] In the context of a country where only 15% of people have access to quality palliative care,[58] Smith predicts:[59]

> "*The expansion will eventually continue to allow people diagnosed with dementia to order themselves killed in an advance directive when they become mentally incompetent and to pediatric euthanasia of 'mature minors' – both among the subjects likely to be 'studied' by a committee of 'experts' over the next two years, meaning they are coming next.*"

concluding:

> "*Slippery-slope argumentation? No. Facts on the ground. Those with eyes to see, let them see.*"[60]

44. In the Netherlands, doctors have been allowed to euthanise patients since 1973, with supposedly 'safe' guidelines that euthanasia be limited to those for whom only death will alleviate overwhelming suffering.[61] However, the shift from an Absolute Value of life to a Conditional Value of life has created the perception that the 'guidelines' were impediments to be overcome rather than protections.[62] Consequently, the requirements to demonstrate

---

[53] David van Gend, 'Unproductive burdens still have a right to live', *The Australian*, 25 March 2011, https://www.theaustralian.com.au/national-affairs/commentary/unproductive-burdens-still-have-a-right-to-live/story-e6frgd0x-1226027674393

[54] Wesley J. Smith, 'Death on demand comes to Germany', *First Things* (New York), 5 March 2020, https://www.firstthings.com/web-exclusives/2020/03/death-on-demand-comes-to-germany

[55] Smith, 'Canada poised to legalize euthanasia…', *op. cit.*

[56] Ibid.

[57] Ibid.

[58] Ibid.

[59] Ibid.

[60] Ibid.

[61] Julian Savulescu, 'Conscientious objection in medicine', *British Medical Journal*, Vol. 332, No 7536, February 2006, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360408/
Wesley J. Smith, 'Continent Death: Euthanasia in Europe', *National Review* (New York), 23 December 2003, https://www.nationalreview.com/article/208967/continent-death-wesley-j-smith

[62] Smith, 'Continent Death: Euthanasia in Europe', *op. cit.*

the alleviation of overwhelming suffering, and multiple requests, soon disappeared.[63] Dutch doctors will now, legally, kill a person who asks for it, whether that person is terminally ill, chronically ill, disabled, or merely depressed.[64]

45. In 2002, Belgium adopted the Dutch-style method of allowing euthanasia with supposedly strict guidelines.[65] Estimates of euthanised people in Belgium in the first year reached 1,000, even though reported numbers (the failure to report itself being a violation of the law) were only 203.[66] Belgian advocates have agitated to expand the categories of people who can be euthanised, including minors and people with degenerative conditions.[67] Further, in Belgium, VAD is considered one of the "treatments" available in palliative care.[68]

46. In Switzerland, the law allows for the facilitation of private suicide and has created an industry in suicide tourism.[69] Organisations such as Dignitas provide services that are not limited to those facing an imminent death.[70] The founder has indicated that he considered severe depression to be irreversible and that he was justified in helping the mentally ill to die.[71]

Children

47. Just as the abandonment of the Absolute Value of life allows for the expansion of the medical conditions that might justify VAD, so too is the age of the patient just one more condition that can be varied.

48. Belgian law allows for euthanasia of a minor if that minor is capable of discernment and conscious at the time of the request for euthanasia.[72] Nevertheless, of the babies aged from 0 to 1 years who died in Flanders, between September 2016 and December 2017, approximately 10 percent – a total of 24 babies – were euthanised because the medical team considered "*there was no hope of a bearable future*".[73] A comparison with a study conducted in 1999 to 2000 suggested that the rate of 10% is an increase from 7% in the earlier study.[74]

49. In 91% of cases, the doctors who euthanised new-borns with lethal injection indicated that the main reason for their action was that, despite a real chance for survival, the medical

---

[63] Peta Credlin, 'Euthanasia is a slippery slope', *Daily Telegraph* (Sydney), 23 June 2019, https://www.dailytelegraph.com.au/rendezview/euthanasia-isnt-dying-with-dignity-its-suicide/news-story/9b37f48a529ce288f6ddc20c303f9620
[64] Smith, 'Continent Death: Euthanasia in Europe', *op. cit.*
[65] Ibid.
[66] Ibid.
[67] Ibid.
[68] Terri Kelleher, 'Strategy to introduce euthanasia by stealth', *News Weekly* (Australia), 30 October 2010, p. 15. https://ncc.org.au/uncategorized/4448-euthanasia-ii-strategy-to-introduce-euthanasia-by-stealth/
[69] Smith, 'Continent Death: Euthanasia in Europe', *op. cit.*
[70] Ibid.
[71] Ibid.
[72] 'Belgium: Euthanasia of new-borns practiced outside of law', European Institute of Bioethics (Brussels, Belgium), 24 June 2021, https://www.ieb-eib.org/en/news/end-of-life/euthanasia-and-assisted-suicide/belgium-euthanasia-of-new-borns-practiced-outside-the-law-2041.html.
[73] Ibid.
[74] Ibid.

team, and possibly also the parents, determined that these children's lives were not worth living until a natural end.[75]

Diagnosis can be Subject to Error

50. A widespread though erroneous public perception is that any person who seeks VAD must be suffering from a condition which is both painful and terminal. However, such a conclusion overlooks the risk of error. Mr Perrottet wrote:[76]

> *"And what about mistakes? Our legal system prizes its cornerstone principle of 'innocent until proven guilty'. The great jurist Lord Blackstone said, 'Better that 10 guilty persons go free than that one innocent party suffer.' And yet, despite this, innocent people go to jail. Lawyers, juries, judges, police and witnesses all make mistakes, because the fact is, no human system of safeguards is infallible.*
>
> *"So with assisted suicide laws. Doctors will make mistakes. Victims will be pressured. Judgments will be clouded, and among all the arbitrary rules and safeguards, only one thing is absolutely certain: innocent people will die at the hands of these laws if they pass. At least the falsely imprisoned can be exonerated and freed years after the fact. For the innocent victims of assisted suicide laws there can be no long-awaited justice, just the silence of the grave.*
>
> *"This is the dark, dangerous void of confusion and contradiction that we are steering our society into if we back these bills."*

51. Nor is this a hypothetical situation. On 21 May 2002, Ms Nancy Crick committed suicide by drinking a solution of Nembutal on the basis that she was suffering chronic pain induced by bowel cancer. However, after undergoing an autopsy, her body was found to be free of cancer, notwithstanding the presence of other causes of the pain she suffered.[77] Nevertheless, the fact is that the decision was made based on an incorrect medical diagnosis. While it might be argued that Ms Crick would have made the same decision if she had received a correct diagnosis, we cannot ask her – for obvious reasons.

Not so Painless a Death

52. As early as 1931, British eugenicist Dr Killdick Millard proposed the legalisation of euthanasia to allow a patient to 'substitute for the slow and painful death a quick and painless one'.[78] This statement contains two assumptions, specifically:

(1) That the patient will suffer a painful natural death.

---

[75] Ibid.
[76] Perrottet, 'Only one certainty …', 1 November 2017, *op. cit.*
[77] 'Nancy Crick didn't know she was cancer-free: son', *The Age* (Melbourne), 25 May 2002, https://www.theage.com.au/national/nancy-crick-didnt-know-she-was-cancer-free-son-20020525-gdu8ma.html.
[78] Michael Cook, '"Quick and painless"? Pull the other one', *MercatorNet* (Sydney), 1 November 2001, https://mercatornet.com/quick-and-painless-pull-the-other-one/75595/

(2) That the euthanised patient will undergo a painless death.

53. The possibility of error as to whether the patient suffers from a terminal condition is set out above. However, there is also considerable doubt as to whether the death offered under VAD is painless.

54. Dr Joel B. Zivot – a licensed physician who works in the intensive care unit at the Emory University School of Medicine in Atlanta, Georgia, where he is also an associate professor of anaesthesiology and surgery – has studied several autopsy reports of prisoners executed with lethal injection, and concluded that many may have died in great pain, noting that both euthanasia and executions use paralytic drugs.[79] He concludes that, in high doses, those drugs can prevent someone from expressing any outward sign of pain, even if they are in extreme distress.[80]

55. In the American state of Oregon, 80% of assisted suicides used pentobarbital which caused pulmonary oedema, causing the lungs to fill with liquid secretions and a person to die in agony.[81] Nor is death necessarily quick, which can be tested as Oregon records information about mode of death, noting that median time to death over 23 years is 30 minutes, but the maximum is 4 days and 8 hours.[82]

56. In Canada, a review of 'assisted dying' found that nearly a quarter of reports described complications, including vomiting and prolonged duration of the dying process.[83] An Irish pharmacist concluded that "*The process of assisted suicide and/or euthanasia cannot guarantee a peaceful, pain free, dignified death*".[84]

57. Dr Lonny Shavelson of Berkeley, California, who is considered to be the leading practitioner of assisted suicide in that state, records that the distress suffered by patients during VAD is being studied in order to learn what conditions might weaken the effectiveness of lethal drugs.[85] Or, described another way, while killing one person, Dr Shavelson records information about his client's death, so that those who offer VAD can more efficiently kill someone else.[86]

Voluntariness

58. The VAD Bill purports to uphold autonomy by requiring a patient to ask for VAD. However, autonomy is only one medical value, with the others being beneficence, non-

---

[79] Joel Zivot, 'Last rights: assisted suicide is neither painless nor dignified', *The Spectator* (USA edition), 16 September 2021, https://spectatorworld.com/topic/last-rights-assisted-suicide-is-neither-painless-nor-dignified/
[80] Ibid.
[81] Ibid.
[82] Michael Cook, 'Quick and painless'? Pull the other one.' https://mercatornet.com/quick-and-painless-pull-the-other-one/75595/
[83] Ibid.
[84] Ibid.
[85] Ibid.
[86] Ibid.

maleficence and justice.[87] It seems that autonomy has been elevated to the primary if not sole criterion for VAD.[88]

59. Further, the autonomy in this context is largely illusory. The entire process of VAD is dependent upon the authority of persons other than the patient who approve every decision leading to the death of the patient.[89] While a person might make the request, the reality is that the decision to make VAD available will always rest with health practitioners who are empowered to decide whether a person's conditions are such that the patient can be legally killed. Schadenberg notes that this is the same internationally:[90]

> "*If you look at Oregon, Washington State, the Netherlands or Belgium – it's the physician who makes the choice.*"

60. Even a clearly expressed decision of a patient may not represent rational autonomy, which requires at a minimum that a person understand the nature, risks and benefits of the procedure or action under consideration, and have a basic understanding of alternatives.[91] Rational autonomy is undermined by cognitive distortions such as the belief that 'no one can help me', or 'no one understands what I'm going through'.[92] A request for VAD may hide underlying wishes, such a covert plea for the physician to be more empathic about the patient's situation, or to test the physician's values.[93] Finally, a person's judgment might also be clouded by emotional factors, as Professor Louis C. Charland, an authority on psychiatric ethics at Western University, in London, Ontario, Canada, and others note:[94]

> "*Emotions such as hope, anger, joy, sadness, fear, and many others ... often play a major role in health care decisions to consent to or refuse treatment, and consent or refusal of* [VAD]*... Yet at present there is no consensus or theoretical vision on how to incorporate such facts into the MacArthur model. Who decides whether hope is appropriate or not, and how do we determine this?*"

61. A patient who is terminally ill may not meet the criteria for a depressive disorder, and still feel hopeless, demoralised, despairing, anticipatory grief over death, or fear that loved ones or physicians will abandon them.[95] All these factors can contribute to a patient seeing VAD as the only way out.[96] Dr Laura Weiss Roberts notes that:[97]

---

[87] Ronald W. Pies and Cynthia M.A. Gepper 'Physician-assisted suicide and the autonomy myth', *Psychiatric Times* (Cranbury, NJ, USA), 28 October 2021, https://www.psychiatrictimes.com/view/physician-assisted-suicide-and-the-autonomy-myth.
[88] Ibid.
[89] Ibid.
[90] Schadenberg, with Russell, *op. cit.*, pp. 12–14.
[91] Pies and Gepper, *op. cit.*
[92] Ibid.
[93] Ibid.
[94] Louis C. Charland, Trudo Lemmens and Kyoko Wada, 'Decision-making capacity to consent to medical assistance in dying for persons with mental disorders', *Journal of Ethics Mental Health*, 2016, pp. 1–14, https://www.researchgate.net/publication/303520825_Decision-Making_Capacity_to_Consent_to_Medical_Assitance_in_Dying_for_Persons_with_Mental_Disorders
[95] Pies and Gepper, *op. cit.*
[96] Ibid.
[97] Laura Weiss Roberts, 'Informed consent and the capacity for voluntarism', *American Journal of Psychiatry*, Vol. 159, No. 5 (2002), pp. 705–712, https://pubmed.ncbi.nlm.nih.gov/11986120/

> *"Suffering and pain due to physical or mental health problems may cause one to move toward a decision out of desperation rather than deliberateness and adherence to personal values...[furthermore], some beliefs and psychological defenses that emerge in the process of dealing with an overwhelming illness may be a barrier to perceiving and considering alternatives."*

62. Further, if the person's decision is based upon economic pressures or personal pressure, that is not really a choice. Schadenberg notes (emphasis added):[98]

> *"But if it comes down to the accountant deciding whether or not there's going to be euthanasia or assisted suicide and whether you're going to live or die – are you then going to call that a choice? Once again, choice is just an illusion. What we're talking about is who makes the decision and about the subtle pressure that is put on people. Here's the reality: people who are looking at the option of euthanasia and assisted suicide are going through a very difficult time in their life. They're in a very stressful, emotionally-charged situation. And now you're throwing in: 'Oh, now euthanasia is an option. We have healthcare demands that are just so out of whack – would you like euthanasia?' And then we add, 'Oh, it's a free choice.' It's not!* ***It's not about choice. It's about eliminating the lives of people who lack a certain level of health or quality of life*** *– that's what it comes down to in the end."*

63. The VAD Bill does provide for assessment of a patient's request by two medical practitioners,[99] with further assistance to assess voluntariness if required;[100] but international experience suggests such measures are of limited value.

64. For example, in Oregon, none of the patients who died by VAD in 2007 were referred for a psychiatric assessment before being killed.[101] A study in the *Canadian Medical Association Journal* examined euthanasia in Belgium and determined that 32% of euthanasia in the Flemish region took place without request or consent.[102]

65. In the Netherlands, despite the inability of babies to request euthanasia, a 1997 study in the British medical journal *The Lancet* estimated that 8 percent of all deaths for Dutch infants came from lethal injection, on the basis that such babies supposedly do not have a 'liveable life'.[103] Nor has the requirement for a request remained a protection among adults. Government studies have estimated that doctors kill approximately 1,000 patients each year who have not asked for euthanasia.[104] Even though the criminal law still defines murder as a crime, the practice is common enough to have its own name: "*Termination without request or consent.*"[105]

---

[98] Schadenberg, with Russell, *op. cit.*, pp. 12–14.
[99] *Voluntary Assisted Dying Bill 2021* (NSW), cl 25-31, 36-42.
[100] *Voluntary Assisted Dying Bill 2021* (NSW), cl 26, 27, 37, 38.
[101] D. van Gend, *op. cit.*
[102] Schadenberg, with Russell, *op. cit.*, pp. 12–14.
[103] Smith, 'Continent Death: Euthanasia in Europe', *op. cit.*
[104] Ibid.;
D. van Gend, *op. cit.*
[105] Smith, 'Continent Death: Euthanasia in Europe', *op. cit.*

66. In examining the situation in the Netherlands in 1993–1994, Lord Walton observed (emphasis added):[106]

> "*We also learned of one specific case in which voluntary euthanasia was accepted by both doctors and lawyers for a physically fit 50 year-old woman alleged to be suffering from intolerable mental stress. We felt particularly uncomfortable about that and about other examples.* ***We concluded that it would be virtually impossible to ensure that all acts of euthanasia were truly voluntary*** *and that any liberalisation of the law in the United Kingdom could not be abused.*"

and concluded that it was not possible to set secure limits on voluntary euthanasia, stating (emphasis added):[107]

> "*we nevertheless returned from our visit feeling uncomfortable, especially in the light of evidence indicating that non-voluntary euthanasia – that is to say,* ***without the specific consent of the individual*** *– was commonly performed in Holland, admittedly for incompetent, terminally ill patients.*"

Coercion

67. In addition to interference with rational autonomy by reason of their condition, a person might also be subjected to coercion to end their life, even if this is expressed in a subtle manner. A decision made under coercion is not rationally autonomous,[108] and the VAD Bill does not satisfactorily address family dynamics or the potentially coercive influences of those who might gain emotionally or financially from a person's death.[109]

68. In 1995, Australia's then Governor-General Bill Hayden gave a speech to the College of Physicians in which he stated: "*There is a point when the succeeding generations deserve to be disencumbered of some unproductive burdens.*"[110] This position was soon echoed by Sir Mark Oliphant, a former state governor of South Australia.[111]

69. As set out under the heading "Voluntariness", international experience demonstrates that far from providing a protection from the loss of rational autonomy through coerced decision-making, the healthcare profession may actually be the source of that coercion, up to and including killing people who have not asked for VAD.

70. In delivering his committee's findings in 1994, Lord Walton stated:[112]

> "*We were also concerned that vulnerable people – the elderly, lonely, sick or distressed – would feel pressure, whether real or imagined, to request early death.*"

---

[106] Walton, *op. cit.*
[107] Ibid.
[108] Pies and Gepper, *op. cit.*
[109] Ibid.
[110] D. van Gend, *op. cit.*
[111] Ibid.
[112] Walton, *op. cit.*

71. Mr Keating recognised the pressure felt by patients, noting (emphasis added):[113]

> "*Once this bill is passed the expectations of patients and families will change. The culture of dying, despite certain and intense resistance, will gradually permeate into our medical, health, social and institutional arrangements. It stands for everything a truly civil society should stand against. A change of this kind will affect our entire community not just a small number of dying patients.* ***It is fatuous to assert that patients will not feel under pressure once this bill becomes law to nominate themselves for termination***."

Professional and Offence Provisions

72. While the VAD Bill provides for professional and criminal sanctions of those who violate the proposed law, it is unclear why such provisions are necessary. As has been set out above, action to harm or end life in NSW is already illegal under the *Crimes Act 1900* (NSW).

73. Further, the presence of such sanctions offers little in the way of protection within a healthcare system that has accepted the Conditional Value of life, where it has been agreed that the ending of a life may in certain circumstances be justified.

74. From an international perspective, we have set out above examples of medical practitioners in the Netherlands killing people without request, including infants. While such actions are illegal, the reality is that those culpable are seldom prosecuted.[114] Of those who are prosecuted, few are convicted, and of those who are convicted, almost none are punished meaningfully.[115] In 2001, prosecutors sought a nine-month suspended probation for a doctor who had been convicted of killing an 84-year-old man who ***had not*** asked for euthanasia.[116] The trial judge considered that too harsh and the appeal court imposed a one-week suspended sentence for killing someone who ***had not*** asked to be killed.[117] Nor does the Dutch Medical Society provide any discipline in such circumstances, as it is currently preoccupied with lobbying to legalise non-voluntary euthanasia.[118] At the same time, the country's Minister for Health advocated for suicide pills to be made available to the elderly who do not qualify for euthanasia under Dutch law.[119]

75. In 2002, Belgium adopted the Dutch-style method of allowing euthanasia with supposedly 'strict' guidelines.[120] The very first reported killing under the Belgian laws violated the legal guidelines and was not punished.[121]

---

[113] Keating, *op. cit.*
[114] Smith, 'Continent Death: Euthanasia in Europe', *op. cit.*
[115] Ibid.
[116] Ibid.
[117] Ibid.
[118] Ibid.
[119] Ibid.
[120] Ibid.
[121] Ibid.

Conscience rights

76. The VAD Bill provides for medical practitioners, health care establishments and residential facilities to refuse to participate in VAD,[122] subject to some exceptions. However:

(1) A medical practitioner who receives a first request in relation to VAD must provide the patient with information specified by the Health Secretary,[123] presumably intended to ensure the patient receives information about VAD.

(2) Medical practitioners must not hinder access to information about VAD.[124]

(3) Residential facilities may be required to permit access by others for VAD purposes.[125]

77. While these provisions appear to provide some form of protection for conscience, which has historically been available in countries such as Australia, Canada, the UK and the USA,[126] there are major problems with that assertion.

Interference with Conscience

78. Where a person believes that VAD is murder, any requirement to support VAD, including by making information about the practice available, is damaging to that person's conscience. Dr Brian Bird, an assistant professor at the Peter A. Allard School of Law at the University of British Columbia, Vancouver, Canada, observes:[127]

> "*Requiring doctors to make the arrangements for procedures that they cannot perform in good conscience is far from a compromise. If you believe it is wrong to rob a bank, would you be willing to plan the robbery?*"

79. Such a requirement might even amount to a form of injury. The Moral Injury Project at Syracuse University, New York, has studied this type of harm in the context of military personnel, but the moral injury might occur in other circumstances:[128]

> "*It is easy to imagine the inner turmoil – even torment – that a nurse or doctor who sees euthanasia as murder will experience if they betray this belief at work.*"

80. Nor is such interference accidental, but rather represents an intentional restriction upon the conscience of a medical practitioner. Melbourne-born bioethicist Dr Julian Savulescu,

---

[122] 'Voluntary Assisted Dying Bill 2021 (NSW): A comparison with legislation in other States', Number 2/October 2021, NSW Parliamentary research Service, page 6.
[123] *Voluntary Assisted Dying Bill 2021* (NSW), cl 21.
[124] Voluntary Assisted Dying Bill 2021 (NSW): A comparison with legislation in other States', Number 2/October 2021, NSW Parliamentary research Service, page 6.
[125] Voluntary Assisted Dying Bill 2021 (NSW): A comparison with legislation in other States', Number 2/October 2021, NSW Parliamentary research Service, page 6.
[126] Julian Savulescu and Udo Schuklenk, 'Doctors have no right to refuse medical assistance in dying, abortion or contraception', *Bioethics*, Vol. 31, No. 3, 2017, p. 163.
[127] Brian Bird, 'Health care without conscience is a dangerous contradiction' (CBC Opinion, Canadian Broadcasting Corporation), 25 August 2021, https://www.cbc.ca/news/opinion/opinion-health-care-without-conscience-dangerous-1.6151611
[128] Brian Bird, 'When conscience is attacked, the ground beneath us shakes', *Public Discourse* (Witherspoon Institute, Princeton, NJ) 10 October 2021, https://www.thepublicdiscourse.com/2021/10/78412/.

founder and current director of the Oxford Uehiro Centre for Practical Ethics in England, asserts that conscientious objection by a healthcare professional to abortion and euthanasia is immoral and should be illegal when it contradicts a medical duty.[129] Savulescu accepts that failing to allow conscientious objection harms the doctor and constrains liberty, but considers that personal values should only be accommodated when such accommodation does not compromise the delivery of services.[130] Savulescu considers this impossible when conscientious objection compromises the quality, efficiency or equitable delivery of a service,[131] stating:[132]

> "*The primary goal of a health service is to protect the health of its recipients.*"

81. Of five mechanisms Savulescu proposes for dealing with conscientious objection, he argues that a medical practitioner who, as he sees it, compromises the delivery of medical services to patients on conscience grounds must be punished.[133] However, as noted by Bird:[134]

> "*If there is any sector of our society where ample space should be granted to conscience, health care is it. Health-care professionals are, first and foremost, called to do no harm.*"

82. Further, the refusal to allow for conscience assumes that healthcare is whatever the state says that it is. Bird answers:[135]

> "*Hostility to conscientious health care is fuelled by the flawed belief that health care amounts to whatever a doctor, nurse or other health-care worker is lawfully permitted to do. To be a good health-care worker therefore means that you must be willing to participate in any service that is categorized by the state as health care, regardless of any ethical qualms you might have.*"

83. Contrary to Dr Savulescu's philosophy, however, the belief that euthanasia involves lethal violence against a human being is a rationally defensible view and deserves a fair hearing.[136] Forcing a doctor to become complicit in the taking of human life is despotism.[137] The Australian Medical Association says (emphasis added):[138]

> "*3.4 If governments decide that laws should be changed to allow for the practice of euthanasia and/or physician-assisted suicide, the medical profession must be involved in the development of relevant legislation, regulations and guidelines which protect:... **patients and doctors who do not want to participate**; and ...*"

---

[129] Savulescu, 'Conscientious objection in medicine', *op. cit.*
[130] Ibid.
[131] Ibid.
[132] Ibid.
[133] Ibid.
[134] Bird, 'Health care without conscience…', *op. cit.*
[135] Ibid.
[136] Ibid.
[137] Wesley J. Smith, 'Canada court; Doctors must euthanize, abort or refer' *National Review* (New York) 16 May 2019, www.nationalreview.com/corner/canada-court-doctors-must-euthanize-abort-or-refer/.
[138] AMA position statement, 22 November 2016, *op. cit.*

84. In Canada, each of the country's major parties refused to support doctors who refuse to refer a patient for procedures they considered to be harmful.[139] The principle of 'live and let live' is fading, and tolerance has been greatly diminished.[140] Consequently:

(1) The Irene Thomas Hospice, a private healthcare facility in Delta, British Columbia, refused to offer euthanasia for ethical reasons, and was shut down by health authorities.[141]

(2) In British Columbia, a private hospice which declined to provide assisted suicide lost its licence to operate.[142]

(3) In Ontario, the superior court ruled that doctors could be forced to facilitate procedures they deem immoral.[143]

85. Not that freedom of conscience is solely for the benefit of medical practitioners. Schadenberg notes:[144]

> "*When I'm at my lowest time in my life, I don't want my doctor to be thinking, 'If I don't kill this guy or send him to someone who will kill him, that I'm going to lose my medical license,'" he pointed out. "I want my doctor to look me in the eye and say, 'I'm not going to do this. ... I have the right to say 'No' to you. I will care for you, but I will not kill you.*"

Reduction of Conscience

86. Once VAD is accepted as legally right, there is simply no longer any legal reason to afford freedom of conscience to those who disagree. Any protections within the VAD Bill are ordinary legislation and can easily be removed by the government of the day.

87. Canada had (theoretically) stronger protections for conscience due to the explicit definition of 'freedom of conscience and religion' as a 'fundamental freedom'.[145] However, once VAD was accepted:

(1) Ontario passed a law requiring doctors to kill legally eligible patients who want to die, or if unwilling to kill a patient, to help the patient find a doctor who will kill them.[146]

(2) When a dispute came before the courts, the trial judge ruled that a right to equal and equitable access to legal and government-funded medical interventions (a right

---

[139] Bird, 'When conscience is attacked', *op. cit.*
[140] Ibid.
[141] Ibid.
[142] Bird, 'Health care without conscience…', *op. cit.*
[143] Ibid.
[144] Lianne Laurence, 'Bioethicists urge ban on doctors' conscience rights: do abortions or quit', *LifeSiteNews* (Canada/USA) 23 September 2017, https://www.lifesitenews.com/news/bioethicists-rebuked-after-calling-for-ban-on-doctors-conscientious-objecti/
[145] *The Canadian Charter of Rights and Freedoms*, Cl 2(a).
[146] Smith, 'Canada court; Doctors must euthanize…', *op. cit.*

which, if it exists at all, is unwritten and implicit) overrides a doctor's explicit freedom of religion.[147]

(3) That decision was affirmed by the Court of Appeals, which ruled that doctors must euthanise or refer patients, whatever religious freedoms or moral objections might exist.[148]

88. Smith concludes:[149]

> "*The point of opposing medical conscience is to drive pro-life and Hippocratic Oath-believing doctors out of medicine. The Court goes there, telling doctors who don't want to euthanize, abort, facilitate sex change, etc., they can always get into hair restoration.*"

89. The professional pressure can also take place on a personal level. In both Belgium and Canada, doctors have been reluctant to propose palliative care options due to the expectation that they will help kill their patients.[150]

Vulnerable People

90. The replacement of the Absolute Value of life with the Conditional Value of life subjects any person to an assessment as to whether their circumstances are such that the termination of their life is legitimate and therefore legal. While there are barriers to such action in the VAD Bill, such as in relation to the mentally ill and the disabled, those barriers are merely legislative provisions that can be easily changed. Schadenberg notes:[151]

> "*So the fact is euthanasia and assisted suicide directly affect the most vulnerable in society.*"

91. As has been set out above, once Conditional Value is accepted as the foundation of the healthcare system, it is legitimate to debate the expansion of those conditions. Further, our review of international experience suggests that physicians need not even wait for legal changes to take place, for they will suffer little if any penalty for expanding those conditions in practice, including in the case of killing people who have not requested VAD.

92. An Australian social commentator and former academic Dr Mervyn Bendle observes that those with terminal illnesses and those who are approaching the end of their life are increasingly apprehensive about what awaits them,[152] noting the opinion of one consultant geriatrician who says that:[153]

---

[147] Ibid.
[148] Ibid.
[149] Ibid.
[150] Simon Caldwell, 'Palliative care and assisted dying – never the twain shall meet', 19 November 2021, https://www.conservativewoman.co.uk/palliative-care-and-assisted-dying-never-the-twain-shall-meet/
[151] Schadenberg, with Russell, *op. cit.*, pp. 12–14.
[152] Mervyn Bendle, 'Yet again, the banality of evil', *Quadrant Online* (Australia) 18 October 2021, https://quadrant.org.au/opinion/qed/2021/10/yet-again-the-banality-of-evil/
[153] Ibid.

"The recent Aged Care Royal Commission showed that older people are a vulnerable group, sounding the alarm on elder abuse, poor care and reliance of 'quick fixes'."

93. Bendle continues:[154]

> *"Many frail elderly will be targeted under the provisions of the VAD Bill and made to feel that they have become a burden and a nuisance to the system, so that 'the 'right' to die becomes the 'expectation' to die. ...[VAD is] the wrong idea at the wrong time."*

94. In the famous 1994 House of Lords debate regarding the report from its Select Committee on Medical Ethics, former dental surgeon Antony Hamilton-Smith (Lord Colwyn) stated that:[155]

> *"It is impossible to set secure limits on voluntary euthanasia without putting undue pressure on vulnerable people to seek this way out of their increased disabilities, distress and loneliness. The committee believed that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death but should assure them of our care and support in life."*

95. In overturning the Northern Territory's euthanasia laws in 1996, Victorian federal Liberal MP Mr Kevin Andrews, then a minister in the Howard Coalition government, stated:[156]

> *"The people who are most at risk are the most vulnerable, and a law which fails to protect vulnerable people will always be a bad law."*

Disabled Persons

96. If the Conditional Value of life is accepted, evaluation of the quality of life could suggest the life of a severely disabled person has limited worth, value or quality, and that it may be more acceptable to prematurely end that life.[157] If it becomes acceptable to justifiably end a life, based solely on the grounds of disability, then a dangerous message is conveyed to those with a disability.[158]

97. Schadenberg asserts that people with disabilities are already vulnerable due to different attitudes and treatment, concluding:[159]

> *"It is not a big jump to see how subtle pressure can be brought to bear on a person who is going through a difficult time in their life. Somebody will say, 'Well, maybe your life would be better off ended.' They don't even have to say that directly; I always talk about subtle pressure because we as human beings, we*

---

[154] Ibid.
[155] Antony Hamilton-Smith (Lord Colwyn) in House of Lords debate on medical ethics findings, *op. cit.*
[156] D. van Gend, *op. cit.*
[157] Heywood and Mullock, *op. cit.*, p. 662.
[158] Ibid., pp. 662–3.
[159] Schadenberg, with Russell, *op. cit.*, pp. 12–14.

understand when we're not really wanted. We get it. And that's what will happen."

98. One of the most significant examples of this is found in the authorisation of a program of euthanasia for the physically or mentally disabled, and the emotionally distraught, in addition to the incurable and the elderly.[160] In Hitler's Germany, the T4 killing centres were established between 1939 and 1940 to murder disabled children and adults who were considered unsuitable to live; but many killings took place in hospitals through starvation, gassing or an overdose of sedatives.[161] Approximately 250,000 people were killed.[162]

Criminals

99. The fundamental premise of the VAD Bill is that a person can be killed because their circumstances are causing them personal suffering. If that premise is accepted, then the state has surrendered any basis upon which it could refuse to execute criminals. Specifically, there would be no justification for protecting the life of a guilty person who has caused others to suffer. While the VAD Bill does not allow for such a thing, the shift to Conditional Value of life removes a significant barrier against such an assessment taking place and then being implemented.

100. It is not submitted that the state would impose a death penalty for shoplifting; but it seems unlikely that the politicians would be eager to protect the life of a person convicted of sexual offences against children, especially in the face of public campaign asserting that the value of that person's life, being conditional, has been diminished by their conduct. Finally, given the international examples set out above, it seems likely that a physician who took it upon themselves to administer VAD to such a person, without having been requested to do so, would not suffer significant penalty, if any.

Limited Economic Means

101. A natural consequence of increased life expectancy is that people will require more assistance and die from more complicated conditions that are more expensive to treat. The economic costs of this care might well be a factor in a person deciding they would prefer to end their life and leave a greater financial bequest to their family. More disturbingly, such an outcome might prompt family members to encourage an elderly relative to consider VAD. Schadenberg observes:[163]

> *"The sad reality is you can't say euthanasia is going to be separate from elder abuse when you consider the course of nature that these people are experiencing. Elder abuse is so underreported – they're talking about only 10 per cent of all elder abuse cases being reported. Why is this? This is because it's happening in a closed family or friend setting where the pressure is very difficult where people say: 'I must have done something wrong; it must be about me'."*

---

[160] Erna Kurbegovic and Colette Leung, 'Sept 1, 1939: Adolf Hitler enacts Action T-4', *The Eugenics Archive* (Social Sciences and Humanities Research Council of Canada, Government of Canada, Ottawa), https://eugenicsarchive.ca/discover/tree/517305eaeed5c60000000029

[161] Ibid.

[162] Ibid.

[163] Schadenberg, with Russell, *op. cit.*, pp. 12–14.

102. Even the government has an economic motivation to reduce the number of people dependent upon palliative care or aged care facilities. Schadenberg notes:[164]

> "*People would say that we can't keep spending more and more on palliative care when we already spend so much on health care. But wait a second. Isn't the priority in an ageing population caring for people who need that care?*"

103. The Australian Medical Association recognises this risk and included in its statement:[165]

> "*3.5 Any change to the laws in relation to euthanasia and/or physician assisted suicide must never compromise the provision and resourcing of end of life care and palliative care services.*"

104. International experience demonstrates that palliative care funding suffers when VAD is legalised. Before permitting VAD in 1997, the state of Oregon ranked highly in the USA for hospice utilisation, pain policy and advanced care planning policy.[166] Since 2000, very few hospices have opened, and palliative care funding and provision have stagnated.[167]

105. The decline in investment in palliative care has also been observed in the Netherlands and Belgium, the latter of which has seen palliative care specialists depart as they saw their function reduced to preparing patients for lethal injections.[168] In Canada, hospices face a loss of funds if they do not offer euthanasia services.[169]

106. In contrast, Lord Walton more than a quarter of century ago reported that his House of Lords select committee had rejected VAD, noting:[170]

> "*Our decision was significantly influenced by the outstanding achievements of the palliative care movement in the United Kingdom; a movement which does not exist in comparable degree in the Netherlands. We are satisfied that the pain and distress of terminal illness can be adequately relieved in the great majority of cases, not only within hospices but also in general hospitals, and in the community through the training of homecare teams and the expertise of general practitioners who are making such care more widely available.*"

Retaining the Absolute Value of Life

107. Notwithstanding the abhorrent nature of the VAD Bill, it is recognised that there are people who suffer ongoing pain and see no prospect of relief save their own death. A person who finds themselves in that situation is deserving of assistance and care, rather than an opportunity to be killed by their medical practitioner.

108. Instead, the Absolute Value of life should be maintained as the foundational principle of the healthcare system, which is characterised by matters including the following:

---

[164] Ibid.
[165] AMA position statement, 22 November 2016, *op. cit.*
[166] Caldwell, *op. cit.*
[167] Ibid.
[168] Ibid.
[169] Ibid.
[170] Walton, *op. cit.*

(1) The proper funding of palliative care, in recognition that palliative care is diametrically opposed to VAD in both theory and practice, and that one can only flourish at the exclusion of the other.[171] As expressed by Lord Walton:[172]

> *"We recommend finally that high-quality palliative care should be made more widely available, that research into new and improved methods of pain relief and symptom control should be adequately supported and its results effectively disseminated and that the training of healthcare professionals should do more to prepare them for the weighty ethical responsibilities which they carry, by giving more priority to ethics and to counselling and communication skills; points now well accepted by the relevant professions and, I am glad to see, by government. And we stress that long-term care of those whose disability and/or dementia makes them dependent should have special regard to the need to maintain the dignity of the individual."*

(2) Rather than empty statements about the equal value of life contained within the VAD Bill, only the provision of high-quality palliative care to all persons can demonstrate that people are equally valued.

(3) In those cases where a person has limited consciousness but is not at risk of imminent death, rather than assessing whether their condition is sufficient to justify taking their life, the community should take the opportunity to surround that person with support and love. Such action becomes self-sustaining, cementing the Absolute Value of life not only to the degree that the recipient is aware of such action, but also among the community members who can then approach their own inevitable death with a degree of confidence in the support of the community around them.

109. Mr Perrottet states:[173]

> *"We need to help those among us suffering through their darkest hour, not push them deeper into the ultimate darkness.*
>
> *"We need more and better palliative care – something we have significantly boosted in this year's NSW state budget, and something that as Treasurer I will continue to push as a matter of priority.*
>
> *"We must not create a two-tier society of the worst possible kind: where there are those whose lives we desperately work to preserve, and those to whom we really will be saying, 'You are better off dead'. I will be voting against the NSW legislation, and I call on all people of goodwill here in NSW and in Victoria to consider these issues and make their voices heard."*

---

[171] Caldwell, *op. cit.*
[172] Walton, *op. cit.*
[173] Perrottet, 'Only one certainty…', 1 November 2017, *op. cit.*

Conclusion

110. We now have overwhelming evidence of what happens in other jurisdictions where VAD is allowed, such as a sharp reduction in palliative and hospice care, the killing of patients ***without*** their consent, and the curbing of conscience rights for medical practitioners for whom the taking of innocent life is abhorrent. Against the proposition that these are international examples which are unlikely to be replicated in Australia, it is submitted that New South Wales has the opportunity to observe the consequences that flow from implementing VAD regimes in other states which have already gone down this path.

111. Far from lagging behind the other states, New South Wales has the opportunity to be the one Australian state where the healthcare system retains the Absolute Value of life, instead of the utilitarian Conditional Value of life. This submission concludes with the words of Cicely Saunders, founder of the modern hospice movement:

> *"You matter because you are you. You matter to the last moment of your life and we will do all we can to help you die peacefully, but also to live until you die."*

SIGNED:

NAME: **John L. Ballantyne**

ROLE: Editor of Australia's *News Weekly* (2004–2015).
Current editor of the newsletter of Endeavour Forum, Inc., an Australian NGO with special consultative status with the United Nations' Economic and Social Council (ECOSOC).

SIGNED:

NAME: Ashley Dewell

ROLE: Solicitor

NAME. Christopher Halloway

ROLE: retired Obstetrician and Gynaecologist

SIGNED:

21.11.2021

NAME: Mark Mudri

ROLE: Member of Executive of Global Council
Advocates International
advocatesinternational.org

SIGNED:

NAME: William Peirson

ROLE: Master

New College

New College Postgraduate Village

UNSW Sydney NSW 2052 Australia.

where the healthcare system retains the Absolute Value of life, instead of the utilitarian Conditional Value of life. This submission concludes with the words of Cicely Saunders, founder of the modern hospice movement:

> *"You matter because you are you. You matter to the last moment of your life and we will do all we can to help you die peacefully, but also to live until you die."*

SIGNED:

NAME: Dr Catherine Peterson

ROLE: General Practitioner

SIGNED:

NAME: Elvis Ivan SEMAN 21/11/21

ROLE: Gynaecologist

I sign as a private citizen & not on behalf of any institutions I am associated with.

SIGNED:

NAME: Alicia H. Smith

ROLE: Cardiac Sonographer NSW

SIGNED:

NAME: DR MARY WALSH MBBS FRACGP

ROLE: GENERAL MEDICAL PRACTITIONER.