Submission No 100

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

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Partially Confidential

To:

Committee Members

The Standing Committee on Law and Justice

26 November 2021

Re: Inquiry into the provisions of the Voluntary Assisted Dying Bill 2021 (NSW)

Dear Committee members

I am a lawyer and an Associate Professor in the Australian Centre for Health Law Research (ACHLR), at the Faculty of Business and Law at QUT.

I should like to make a submission in respect of the Voluntary Assisted Dying Bill 2021 (NSW) based on my academic research into this field.

My submission relates to Part 4 Division 2 of the Bill, which deals with administration decisions.

For reasons stated below, it is legally and ethically better if the default position be a self-administration decision, with practitioner-administration to be available only in exceptional circumstances—where, for example, the patient is unable to self-administer or for other reasons practitioner-administration decision is more appropriate.

The reason why the default position should be self-administration is that there are extra protections provided by the requirement of self-administration:

1. The act of self-administration is itself the final indication that the person is acting truly voluntarily because self-administration is the final lethal act, and is undertaken by the patient himself or herself, and not a third-party. This option thereby maximises the person's autonomy to control the timing and circumstances of their death and ensures that, at the moment of the fatal act, the patient's decision remains voluntary.
2. Requiring the person to self-administer the substance (save in exceptional circumstances) provides an additional safeguard over practitioner-administration; if patients have to administer the dose themselves, they might be more likely to discontinue the process if they have any residual doubts at the crucial moment. These doubts may not be uncovered by the existing safeguards which attempt to ensure that the decision is truly voluntary. If a patient has opted for practitioner-administration and has arranged the relevant appointment with practitioner to have the practitioner administer the fatal dose, there may be pressure to go through with it even when the patient has last-minute doubts. The patient may worry about their credibility if they change their mind or express last-minute doubts but may not volunteer these worries. They may also worry whether they could arrange another appointment if they change their minds again and decide that they want VAD after all. These two psychological pressures are absent when the choice is to self-administer the substance. This is why a default self-administration framework is better.
3. There is well-known evidence that approximately one out of three people given the option to self-administer a substance do not actually go on to self-administer the substance (See

Public Health Division. Oregon Death with Dignity Act 2020 Data Summary. Oregon: Oregon Health Authority; 2021.) Merely having reassurance that they could end their lives when they wish provides sufficient relief from the burden of otherwise not knowing how they will die for these people, and accordingly they never reach the stage of actually feeling the need to end at their lives.

4. Self-administration may also more readily assuage the concerns of medical bodies and institutions who conscientiously object to voluntary assisted dying on the basis that such practices are repugnant to the values of the medical profession. The concern of these medical institutions is more readily understandable in the case of practitioner-administration, since this involves one person killing another person. By contrast, self-administration does not involve any practitioner in the actual act of ending another person's life. Instead, the person who has requested access to voluntary assisted dying ends their own life.

On some views, allowing a patient to decide whether to self-administer or have practitioner-administration enhances their autonomy. However, the counterargument is that it is having the very option of voluntary assisted dying that promotes autonomy, rather than merely the detail of how that decision is carried out. What is more, the extra protection involved in requiring self-administration *enhances* autonomy to the extent that it ensures that the decision right up to the very last moment remains the personal decision of the requester.

Some researchers, myself included, claim that there is clear empirical evidence that both self-administration and practitioner-administration are safe (https://theconversation.com/as-victorian-mps-debate-assisted-dying-it-is-vital-they-examine-the-evidence-not-just-the-rhetoric-84195). My comments above are not meant to cast any doubt on that empirical evidence. However, the limitations of this empirical research must also be acknowledged. Quantitative data will sometimes be too coarse-grained to show whether some people can feel residual doubts but not volunteer these doubts (See I G Finlay and R George, 'Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the impact on patients in vulnerable groups – another perspective on Oregon's data' (2011) 37(3) *Journal of Medical Ethics* 171). Given that self-administration still protects the autonomy of those patients who want to end their lives and can add the extra layer of safety discussed, the argument for making self-administration the default option is compelling.

Finally, please note that while I make this submission as a member of the Australian Centre for Health Law Research, the points in this submission represent my views only as a result of my own

research (and some research with colleagues), but should not be taken to represent the views of other members of the Centre.

With best wishes

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