Submission to the Legal And Social Issues Committee of the Victorian Parliament on its inquiry on the need for laws in Victoria to allow citizens to make informed decisions regarding their own end of life choices

My name is David St Leger Kelly. I am a former Secretary to the Law Department (now, Attorney-General's Department) of the Victorian Government; and former Chair of the Victorian Law Reform Commission. I was one of the main drafters of the Victorian Euthanasia Society's draft bill to legalise medical assistance in dying, which formed the basis of the Northern Territory's legislation on the subject many years ago.

I thank the Legal and Social Issues Committee of Parliament for the opportunity to make a submission in relation to its enquiry "on the need for laws in Victoria to allow citizens to make informed decisions regarding their own end of life choices". My submission is in two parts.
Part 1

I strongly support the view that the present law, which makes it an offence to assist a person to commit suicide, should be amended to allow a doctor to provide medical assistance in dying.

The essential reasons for my support are set out briefly in the following six main points. They are directed only at cases where a competent, informed, terminally ill patient, who is experiencing intolerable and unrelievable pain or suffering, has formally asked a doctor for medical assistance in dying; and where that doctor is willing to provide that assistance. At the end of my submission, I deal briefly with cases where, because of disability, the patient is not competent to make a formal request.

1. The law should only be used to criminalise conduct on the basis that it causes harm to others. "Harm" includes conduct that causes physical or mental harm, but does not include any form of supposed detriment that is solely in the form of what is sometimes called "moral" or "self" harm. Even if conduct does cause harm to others, that is not a sufficient ground in itself for forbidding the conduct. The harm caused by the conduct must outweigh the harm caused by forbidding the conduct.

2. Even if harm may be caused to others when a patient decides to accept medical assistance in dying – for example, psychological harm to relatives of the patient – that harm is far outweighed by the harm that would be caused to the patient if his or her autonomy were to be denied. More general types of harm to others that have been identified by opponents of medical assistance in dying are speculative and implausible.

3. The present law effectively deprives terminally ill patients of the possibility of receiving medical assistance in dying. It denies them autonomy and breaches their human rights.

4. Acceptance of propositions 1–3 does not involve any denial of the principle that doctors are, and should continue to be, committed to maintaining human life.

5. Some opponents of medical assistance in dying claim that it is unnecessary; terminally ill patients could be helped to die through expert palliative care, instead. The availability of palliative care raises separate issues from whether the law forbidding medical assistance in dying needs to be reformed. It should not be used to deflect attention from the need
for patients to have other options from which to choose in managing the ends of their lives. It should not be used as a mask for a denial of human rights.

6 Clear evidence is available that a substantial majority of Victorians (and Australians generally) support the right of a terminally ill patient to receive medical assistance in dying; and the right of a willing doctor to provide it.

I will now explain each of these six points:

1 The law should only be used to criminalise conduct on the basis that it causes harm to others. "Harm" includes conduct that causes physical or mental harm, but does not include any form of supposed detriment that is solely in the form of what is sometimes called "moral" or "self" harm. Even if conduct causes harm to others, that is not a sufficient ground in itself for forbidding the conduct. The harm caused by the conduct must outweigh the harm caused by forbidding the conduct.

This principle is a shorthand way of stating the gist of what John Stuart Mill had to say in *On Liberty*. There is little point in setting out all of Mill's views, or examining their precise limits. The principle I have stated reflects a utilitarian approach. It also reflects the liberal tradition in relation to the role of law in a free society.

Of course, not everyone one is a utilitarian or even a liberal. People of a religious persuasion, for example, base their moral principles, and often their socio-political principles, on the nature or will of God, as divinely revealed. Faced with non-believers and their humanist views, many religious people now base their arguments against proposals to allow choice not on perceived divine revelation, but on different grounds – usually, the dread consequences of making any change to existing law. That form of argument is often called the "slippery slope" argument.

Sometimes, a slippery slope argument is patently absurd. A recent (hopefully isolated) example is the suggestion that to legalise same-sex marriage could lead to proposals allowing for marriage between humans and animals! Of course, slippery slope arguments are not always so silly. But they should always be treated with caution. In many cases, they rest on assertions as to consequences that are entirely speculative.
2 Even if harm may be caused to others when a patient decides to accept medical assistance in dying – for example, psychological harm to relatives of the patient – that harm is far outweighed by the harm that would be caused to the patient if his or her autonomy were to be denied. More general types of harm to others that have been identified by opponents of medical assistance in dying are speculative and implausible.

In relation to harm to relatives, this point is surely self-evident. In the case of a terminally ill patient who is experiencing intolerable and unrelievable pain or suffering, the suffering of his or her relatives is simply not comparable with that of the patient.

However, those who oppose providing medical assistance in dying to terminally ill patients often point to another form of harm: the dread general consequences of allowing doctors to help terminally ill patients to die. That is a typical slippery slope argument.

The first dread consequence that they rely on is that allowing medical assistance in dying would lead to patients being assisted to die in other circumstances as well. Indeed, it might provide a convenient cloak for the actual murder of some vulnerable patients.

The problem with that argument is that it takes no account of the fact that recent proposals to allow doctors to provide medical assistance in dying incorporate stringent procedures and conditions to ensure that abuse is prevented. A doctor who failed to comply with those procedures and conditions would continue to commit an offence.

In fact, the risk of an abuse of a patient's rights is much greater under the present law than it would be under a properly drafted amendment to the existing law. The procedural and auditing requirements that the proposals incorporate simply do not exist at present. Doctors are not subject to any reporting requirements at all, except those relating to the reporting of death. Effective oversight of their practices is lacking.

The second dread consequence that opponents rely on is that to allow doctors to provide medical assistance in dying would lead to a general diminution in respect for life. It could lead to unpredictable developments (even state-sanctioned ones) that might put the lives of the sick and elderly, in particular, at grave risk. That form of the argument is equally implausible.

To allow, subject to stringent safeguards, the provision of medical assistance in dying to a terminally ill, competent and informed, adult patient who has
formally asked for that assistance would affirm society's respect for human life and individual autonomy, not undermine it. It would demonstrate society's total commitment to maintaining the right of patients alone to decide what medical treatment they are to be given. The procedures that have been laid out in various recent proposals underline the paramountcy of the patient's informed request for assistance; and provide a detailed protective audit trail to enforce it.

It is important to note that slippery slope arguments of the type put forward in this country against allowing medical assistance in dying were carefully considered by the Canadian Supreme Court in 2015 in Carter v Canada (Attorney General). They were unanimously rejected (see below, in relation to point 3).

3 The present law effectively deprives many terminally ill patients of the possibility of receiving medical assistance in dying. It denies them autonomy and breaches their human rights.

The concept of human rights is, of course, still in the process of development. It is not as legally well recognized in Australia as it is in many other countries. In particular, a breach of human rights in Victoria is not a basis on which an existing law can be struck down. But the direct relevance of human rights to decisions on what the law ought to be is beyond question.

Leading international cases at the highest level establish that the right to request medical assistance in dying is a basic human right in cases where the patient is terminally ill. That right is clearly denied when the law forbids a willing and informed doctor to provide that assistance to a competent adult patient who has formally requested it.

In 2015, the Supreme Court of Canada in Carter v Canada (Attorney General) decided unanimously that a blanket ban on medical assistance in dying was contrary to the Canadian Charter of Rights and Freedoms. That is compelling evidence that the concept of human rights includes the right of a terminally ill patient to make end of life decisions. As a Canadian Bar Association summary puts it:

The Court determined that gravely ill individuals have the right to seek an assisted death within the medical context of a physician-patient relationship. Specifically, the Court declared that the laws that prohibit a physician’s assistance in terminating life are unconstitutional insofar as they prohibit physician-assisted dying for a competent adult who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.
As another comment (by Impact Ethics, Faculty of Medicine, Dalhousie University (Halifax, Canada) points out:

*The Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society. This means that limits on rights must be prescribed by law, they must serve a pressing and substantial objective, and the means used must be proportionate to the ends. For the means used to be proportionate to the ends, there must be a rational connection between the means and ends, the means chosen must minimally impair the rights being limited, and there must be proportionality as between the deleterious and salutary effects of the rights limitation.

The Supreme Court found that a total ban on physician-assisted death does not minimally impair the right to life, liberty and security of the person since a less restrictive regime could achieve the objective of the prohibition. Specifically, vulnerable Canadians could be protected while allowing a subset of Canadians to access physician-assisted death. Therefore, the prohibition of physician-assisted death limited section 7 rights, was not saved by section 1, and so violated the *Charter*.

I would also refer the Committee to the 2014 decision of the Supreme Court of the United Kingdom (formerly, the House of Lords) in *R (on the application of Nicklinson and another) (v Ministry of Justice [2014] UKSC 38.*

I cite that case because of the clear recognition that section 2 of the UK law on assisted suicide (which is to much the same effect as our own law against assisted suicide) is in breach of the requirements of the European Convention on Human Rights. The court reached its conclusion by a majority of 5 to 4 on the basis that section 2 of the UK's blanket ban on assisting suicide ignored the range of circumstances in which the issue could arise – in particular, cases where terminally ill patients were suffering dreadfully by reason of their inability to obtain medical assistance in dying. A blanket ban of that type was an infringement of the European convention.

The leading majority judgment set out the relevant parts of the Convention in the following terms:

Article 2, in summary form, guarantees the right to life, and, unsurprisingly, it is an unqualified right. Article 8.1 entitles everyone to “respect for his private … life”. This right is qualified, as article 8.2 prohibits any “interference by a public authority with the exercise of this right” unless (i) “it is in accordance with the law”, and (ii) it “is necessary in a democratic society, … for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Five members of the Supreme Court indicated that they regarded the blanket ban under UK law as an infringement of the Convention. However, three of
them, along with the minority judges, agreed that they should not make such a
declaration before giving the UK Parliament the opportunity to change the law
so that it met the requirements of the Convention. As Lord Neuberger put it:

In my opinion, before making such a declaration, we should accord Parliament the
opportunity of considering whether to amend section 2 [the existing law] so as to enable
Applicants, and, quite possibly others, to be assisted in ending their lives, subject of course to
such regulations and other protective features as Parliament thinks appropriate, in the light of
what may be said to be the provisional views of this Court, as set out in our judgments in
these appeals.

Lady Hale and Lord Kerr, also majority judges, would have gone further. They
stated that the incompatibility between section 2 and the Convention was so
clear that a declaration to that effect should be made without delay. It would
then be for Parliament to make the changes required to make UK law
compatible with the convention.

The UK Supreme Court's decision may be difficult to analyse because it deals
with issues and concepts peculiar to the European Union. However, human
rights are not limited to Europe; and a close examination of the judgments
makes it clear that the majority of the judges recognised that the UK law denied
the human rights of some terminally ill patients; and that medical assistance in
dying should therefore be allowed in some circumstances.

The fact that the Supreme Courts of both Canada and the UK have decided that
blanket bans on medical assistance in dying are a breach of human rights is
surely an independent and overriding reason for recommending the
abandonment of similar blanket bans in this country. We should all turn our
attention to the circumstances in which that assistance should be legalised, and
the procedures that should be followed when it is provided.

4 Acceptance of propositions 1–3 does not involve any denial of what
many see as the principle that doctors are, and should continue to be,
committed to maintaining human life.

The argument has often been put that doctors should never be allowed to
provide medical assistance in dying because the provision of that assistance
would breach the principle that their role is to maintain life, not to destroy it.
That argument is intellectually unsustainable.

When one adopts a principle, one is not committed to following it in every case.
A principle is an injunction that must be taken into account in making a
decision. It is not a binding rule that must be followed in all cases to which it applies. A moment's reflection will establish that fact.

Take the principle that doctors should be committed to maintaining human life. Suppose that a patient has suffered an injury that requires life support to keep him or her alive. Suppose, further, that there is no reasonable hope of the patient recovering consciousness. He or she is agreed to be brain dead. What are the doctor and the patient's relatives to do in that situation? Most doctors today recognize that the patient's life support system may have to be switched off. Most relatives also reach that conclusion. Most hospitals agree. In many cases, after careful consideration, the decision is taken to switch off the life support system.

When that is done, no-one is involved in denying the principle that doctors should be committed to maintaining human life. That principle has been not been applied in the particular circumstances because another fundamental principle – one against pointlessly continuing life by "artificial means" – has trumped it. And that is precisely what happens to particular principles all the time. They assist us in making decisions, but none of them is the critical one in all cases. Everything depends on a consideration of all the circumstances.

The same applies in relation to the maintenance of life principle in the present context. Doctors and patients also recognize the principle that a doctor is, and should continue to be, committed to preventing needless pain and suffering. Which of these principles should be applied in relation to medical assistance in dying is not governed by either of those principles. Each must be considered before an informed decision can be made. In some cases, the "maintenance of life principle" may be judged the appropriate one to apply; in others, the "prevention of pain principle", instead.

It is an intellectual error to treat either principle, on its own, as a reason against, or for, a change to the law on assisted suicide. One must take both into account. The choice between them depends on a consideration of all the circumstances of the particular case, not on ideology.
Some opponents of medical assistance in dying claim that it is unnecessary; terminally ill patients could be helped to die through expert palliative care, instead. The availability of palliative care raises separate issues from whether the law forbidding medical assistance in dying needs to be reformed. It should not be used to deflect attention from the need for patients to have other options from which to choose in managing the ends of their lives. It should not be used as a mask for a denial of human rights.

The availability of palliative care is to be welcomed. However, its extension raises separate issues from whether the law forbidding medical assistance in dying needs to be reformed. In the medical field, there are numerous competing calls for additional resources. Expressions of concern are often made by the AMA and others about the inadequate funding of various areas of medical practice. The extent, if any, to which funding precedence should be given to palliative care over other forms of medical treatment is a matter for government, after consultation with service providers and patient representatives.

The existence of palliative care should never be used as an argument against amending the law to recognise the human rights of patients who are terminally ill and who want medical assistance in dying. Some patients who are in receipt of palliative care still experience intolerable and unrelievable pain or suffering. Moreover, many patients simply do not want that type of care. Palliative care cannot be imposed on patients. It should always be left to patients, properly informed about all the options, including palliative care, to decide how to manage the end of their lives.

Clear evidence is available that a substantial majority of Victorians (and Australians generally) support the right of a terminally ill patient to receive from a willing doctor medical assistance in dying; and the right of a willing doctor to provide it.

Others will have referred the Committee to the surveys that have been regularly carried out on public attitudes towards the issue. The public support for a change to the present law is overwhelming. Continuance of that law will condemn a great many people to utterly needless, unrelievable pain and suffering. For that, there is no justification.
Part 2

If a change to the law of the type that I support is to be recommended by the Committee, a number of important issues will also need to be dealt with:

- It would obviously be inadequate merely to amend the existing law by excepting doctors from its provisions. Members of the public would rightly demand specific regulation of the exercise by doctors of the right to provide medical assistance in dying. In my view, the procedures and conditions that have been developed over recent years by Dying with Dignity Victoria provide an appropriate starting point. Others will have drawn the Committee's attention to these. They include protection for the rights of hospitals, doctors etc to decline to provide medical assistance in dying.

- Recent proposals for amending the law have generally been restricted to the provision to the patient of a lethal dose of a drug which the patient is then free to self-administer. My personal belief is that this is an unnecessary restriction. Wherever possible, law reform should enunciate principles, not detail. The principle is not affected by the particular form that the provision of medical assistance in dying takes. The drug should not have to be self-administered. In many cases, injection of the drug, at the patient's request, by the treating doctor would be the preferable method. Limiting the provision of medical assistance to providing a drug that has to be self-administered discriminates against patients who have become disabled after making a formal request for the relevant assistance.

- Recent proposals for amending the law have also been restricted to patients who are competent at the time of making a formal request for medical assistance in dying. I believe that that restriction involves unwarranted discrimination against mentally disabled patients. If the type of amendment to the law that I support were to be adopted, the Committee should seriously consider developing provisions that would remove that discrimination. The law has already adopted provisions which grant to an independent body (the Public Advocate) the right to make various decisions for the benefit of persons who are not competent to make those decisions themselves. Those
provisions have worked extremely well. Similar provisions would be appropriate in the present context as well.

David St L Kelly

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