

Ms Lizzie Blandthorn MP

Chair

Scrutiny of Acts and Regulations Committee

Parliament of Victoria Spring Street

East Melbourne VIC 3002

By email: Nathan.bunt@parliament.vic.gov.au

12 October 2017

Dear Ms Blandthorn,

### **The Voluntary Assisted Dying Bill 2017**

As provided for in section 17(a)(viii) of the Parliamentary Committees Act 2003, the Scrutiny of Acts and Regulations Committee can consider and report on any Bill introduced into the Assembly which is inconsistent with:

“The Charter of Human Rights and Responsibilities (hereafter the Charter) is outlined in Charter of Human Rights and Responsibilities Act 2006.”

I tender this submission to the Committee as an independent academic at the Australian Centre for Christianity and Culture, Charles Sturt University.

#### **Summary of the submission**

It is argued that the questions of incompatibility exist between the Voluntary Assisted Dying Bill 2017 (hereafter the VAD) and 9 and 10(c) of the Charter. The Minister’s Statement of compliance with the Charter in relation to s13 and s21(1) is also contested.

Section 9 of the Charter states that:

‘Every person has the right to life and has the right not to be arbitrarily deprived of life’

It is claimed that:

1. The purpose of the VAD is to vacate the right enjoyed under s9 of the Charter for persons deemed to eligibility criteria of the VAD;
2. That there are grounds to assert that the VAD would operate in such a manner that eligible persons would be 'arbitrarily deprived of life';
3. Specifically, the VAD breaches s9 of the Charter for persons who are vulnerable to risks of misadministration of safeguard measures outlined in the VAD in the areas of mental illness, degenerative disability and elder abuse on the basis that the safeguards are insufficient to meet the requirements of the Charter based on international experience and scientific studies.

There are also grounds to assert incompatibility of the VAD with the Charter in relation to section 10(c) of the Charter that states that a person must not be 'subjected to medical ... treatment without his or her full, free and informed consent'. It is argued that the test of informed consent in the VAD is deficient on the basis of international experience and scientific studies.

The Minister's statement of compliance with Charter asserts that s13 and s21(1) of the Charter require that persons who meet eligibility requirements under the VAD have a right to privacy which should allow them to make a free choice to end their life according to their preferences (s13) and that the right to personal liberty and security under s21(1) also encompasses the principle of autonomy which should similarly allow them to make this free choice. This is contested on the basis that this expansive interpretation of the Charter is speculative and not in the public interest. The Charter should be interpreted strictly in its plain reading.

It is argued that the VAD should not proceed for consideration of the Parliament until fundamental human rights concerns listed above are addressed or alternatively should be addressed in the Parliament's consideration of the VAD.



Dr Brendan Long  
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October 2017

# UnSafeguards

Submission to the Scrutiny of Acts and Regulations  
Committee of the Victorian Parliament in relation  
to the Voluntary Assisted Dying Bill

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Dr Brendan Long,  
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October 2017

## **Functions of the Scrutiny of Acts and Regulations Committee in relation to this submission**

The functions of the Scrutiny of Acts and Regulations Committee (hereafter the SARC) are set out in section 17 of the Parliamentary Committees Act 2003. This Act under s17(a) states that it is the function of the SARC:

“to consider any Bill introduced into the Council or the Assembly and to report to the Parliament as to whether the Bill directly or indirectly –

- (i) trespasses unduly upon rights or freedoms;
- (ii) makes rights, freedoms or obligations dependent upon insufficiently defined administrative powers;
- (iii) makes rights, freedoms or obligations dependent upon non-reviewable administrative decisions;
- (iv) unduly requires or authorises acts or practices that may have an adverse effect on personal privacy within the meaning of the *Privacy and Data Protection Act 2014*;
- (v) unduly requires or authorises acts or practices that may have an adverse effect on privacy of health information within the meaning of the *Health Records Act 2000*;
- (vi) inappropriately delegates legislative power;
- (vii) insufficiently subjects the exercise of legislative power to parliamentary scrutiny;
- (viii) is incompatible with the human rights set out in the *Charter of Human Rights and Responsibilities ...*”

The Charter of Human Rights and Responsibilities (hereafter the Charter) is outlined in Charter of Human Rights and Responsibilities Act 2006. This submission makes particular reference to s9 and s10(c) of this act as outlined below:

### **9. Right to life**

Every person has the right to life and has the right not to be arbitrarily deprived of life.

### **10. Protection from torture and cruel, inhuman or degrading treatment**

A person must not be—

- (a) subjected to torture; or
- (b) treated or punished in a cruel, inhuman or degrading way; or
- (c) subjected to medical or scientific experimentation or treatment without his or her full, free and informed consent.

The submission also responds to the Minister statement of compliance with the Charter in relation to sections 13 and 21(1) of the Charter.

### **13. Privacy and reputation**

A person has the right—

- (a) not to have his or her privacy, family, home or correspondence unlawfully or arbitrarily interfered with; and
- (b) not to have his or her reputation unlawfully attacked.

### **21. Right to liberty and security of person**

- (1) Every person has the right to liberty and security.

## **Arguments presented in relation to the impact of Voluntary Assisted Dying Bill 2017 on The Charter of Human Rights and Responsibilities as outlined in Charter of Human Rights and Responsibilities Act 2006.**

### **Summary**

It is argued that the questions of incompatibility exist between the Voluntary Assisted Dying Bill 2017 (hereafter the VAD) and 9 and 10(c) of the Charter. The Minister's Statement of compliance with the Charter in relation to s13 and s21(1) is also contested.

Section 9 of the Charter states that:

'Every person has the right to life and has the right not to be arbitrarily deprived of life'

It is claimed that:

4. The purpose of the VAD is to vacate the right enjoyed under s9 of the Charter for persons deemed to eligibility criteria of the VAD;
5. That there are grounds to assert that the VAD would operate in such a manner that eligible persons would be 'arbitrarily deprived of life';
6. Specifically, the VAD breaches s9 of the Charter for persons who are vulnerable to risks of misadministration of safeguard measures outlined in the VAD in the areas of mental illness, degenerative disability and elder abuse on the basis that the safeguards are insufficient to meet the requirements of the Charter based on international experience and scientific studies.

There are also grounds to assert incompatibility of the VAD with the Charter in relation to section 10(c) of the Charter that states that a person must not be 'subjected to medical ... treatment without his or her full, free and informed consent'. It is argued that the test of informed consent in the VAD is deficient on the basis of international experience and scientific studies.

The Minister's statement of compliance with Charter asserts that s13 and s21(1) of the Charter require that persons who meet eligibility requirements under the VAD have a right to privacy which should allow them to make a free choice to end their life according to their preferences (s13) and that the right to personal liberty and security under s21(1) also encompasses the principle of autonomy which should similarly allow them to make this free choice. This is contested on the basis that this expansive interpretation of the Charter is speculative and not in the public interest. The Charter should be interpreted strictly in its plain reading.

It is argued that the VAD should not proceed for consideration of the Parliament until fundamental human rights concerns listed above are addressed or alternatively should be addressed in the Parliament's consideration of the VAD.

## Response to the Minister's Statement of Compliance with the Charter

- **Judgements of Parliaments in the UK, Scotland and New Zealand.**

The Minister has stated in her Statement of Compliance with the Charter that the right to life as defended in s9 of the Charter is protected due to the prevalence of adequate safeguards in the Bill. This is contested in relation to the following areas of concern.

This type of legislation was rejected in the UK, Scotland and New Zealand due to concerns around the efficacy of safeguards to guarantee the intent of the Parliament. Such safeguards were not judged to sufficiently mitigate against the risk of unintended consequences associated with reliance on such measures for people with mental illness and persons with degenerative disability against the intent of the Parliament and the risk of elder abuse including inheritance impatience.

- The House of Commons in the UK rejected a euthanasia bill in September 2015 by a vote of 330 against to 118 in favour (see <https://www.ft.com/content/f791f80c-58a0-11e5-9846-de406ccb37f2>)
- In Scotland in May 2015 Holyrood rejected a euthanasia bill by a vote of 82 to 36 (see <http://www.bbc.com/news/uk-scotland-scotland-politics-32887408>)
- In New Zealand euthanasia bills were rejected in 1995 and 2003 with David Seymour's new Private Member's Bill not gaining a Second Reading in the life of the current New Zealand Parliament.

While many reasons were offered in opposition to these bills the lack of confidence in the safeguards for vulnerable persons was a critical consideration that led to their defeat. On this issue the views of medical professional were valued highly.

In the UK in a 2015 survey of 1,000 doctors only one in seven doctors indicated that would be prepared to consider a request for assisted dying. (<http://www.telegraph.co.uk/news/uknews/assisted-dying/11857701/Assisted-suicide-or-assisted-dying-has-no-place-in-our-healthcare-system-doctors-dont-want-it.html>).

While no survey of doctors is available in Victoria there is little reason to expect a widely different conclusion. The concerns held by politicians in the UK, Scotland and New Zealand have not been addressed in the current Bill in Victoria.

The Bill does not appear to provide greater safeguards than the bills which were rejected in the UK, Scotland and New Zealand.

- **Concerns for people with mental illness**

There is a strong risk that dying people with mental illness will activate the assisted suicide process as a result of their mental infirmity rather than a decision relating solely to their primary medical condition. The evidence from the overseas jurisdiction is that demand for access to PAS for those with mental illness has increased dramatically.

As stated in the End of Life Choices Inquiry Report (p.414)

“The proportion of euthanasia deaths involving neuropsychiatric disorders has increased sharply in Belgium over the past decade, from 1.2% of cases in 2004/05 to 2.8% in 2010/11 (58 cases) and 3.7% of cases in 2013/14 (67 cases).”

**Table 4: Number of cases of euthanasia for neuropsychiatric conditions in Belgium<sup>79</sup>**

Source	Years covered by report	Number of cases of neuropsychiatric conditions
Second report	2004 and 2005	9 <sup>80</sup>
Third report	2006 and 2007	13 <sup>81</sup>
Fourth report	2008 and 2009	62
Fifth report	2010 and 2011	105

And on page 415 of the same report.

“In the Netherlands, recent data from reports of the Regional Euthanasia Review Committees points to a growing number of cases of euthanasia in cases of mental illness and dementia. Table 5 contains the number of cases of mental illness and dementia over the period 2012-2015.”

“There is no reason to think that growth rates in either category will taper off given what we observe in growth rates in the overall number of cases both in the Netherlands and other major jurisdictions.”

**Table 5: Number of cases of euthanasia for mental illness or dementia in Netherlands<sup>82</sup>**

Year	Mental Illness (Cases)	Dementia (Cases)
2012	14	42
2013	42	97
2014	41	81
2015	56	109
Growth rate: (CAGR 2012-2015)	59%	37%

Part of this growth in the mental illness cohort is due to difficulties in assessing mental capacity for patients in end of life situations. Research from respected Australian medical professionals in a paper to Palliative and Supportive Care (2015), 13, 1399–1409. Cambridge University Press, 2015 1478-9515/15 highlights the problem.

"Even when psychiatrists are involved, their capacity to confidently assess the existence and role of mental illness in EAS has been questioned (see: <http://jme.bmj.com/content/37/4/205.short>). Assessing mental capacity, a common requirement for jurisdictions where euthanasia and physician-assisted suicide are legalised, can also be problematic for doctors (see <https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-15-32>)."

Mental illness is notoriously difficult to diagnose. There are two problems. The first is that it is a hidden disease. Without specialist clinical training, or a developed personal case history for the client, it is not easy for a GP to be able to distinguish mental illness from normal mood cycles or occasional aberrant behaviour. A GP faces significant challenges in distinguishing mental illness from a certain level of anxiety or depression that could be expected to be experienced by any patient facing a terminal illness. There is therefore a significant risk that a GP, when facing a referral for assisted suicide or euthanasia, may simply fail to identify latent mental illness and therefore fail to call for a psychological assessment of a dying patient who in fact seeks suicide as result of their mental illness.

Perversely, the increased prevalence of mental illness in the community may also exacerbate the difficulties with diagnosis. Data from the Australian Institute of Health and Welfare (AIHW) reveals a rapid rise in the mental illness cohort in the overall population in recent years. In *Mental Health Services in Brief* (2016, p.6) AIHW estimates that

“the incidence of mental health related encounters has increased by a rate of 4.4% per year between 2010-11 and 2014-15. “

This is a dramatic annual growth rate. When it becomes a daily reality in a GP clinic that clients may present with some signs of risks of mental illness, the diagnosis of psychological pathology, as distinct from an episodic mild depression, which is a natural response to diagnosis of a terminal disease, becomes a fine judgement. Many GPs will not be clinically trained to evaluate this situation. One way of determining if the mood change is a normal reaction or a pathological one is observing the patient over time but time is not a resource available to dying person and their GP. Diagnosis of mental illness is also a function of the depth of trust in the doctor-patient relationship. It is often easy to hide depression or anxiety when it is mild or moderate. This exacerbates the risk that a GP might fail to trigger a psychiatric assessment for a terminal patient with mental illness.

When we consider the international evidence, there are increased grounds for caution. As stated above, the evidence available from Belgium and Holland, which has allowed assisted suicide and euthanasia for many years, shows a concerning rapid rise in people with mental illness seeking access to euthanasia. In Belgium the proportion of deaths from euthanasia that involved psychiatric disorders has risen from 1.2% of cases in 2004/5 to 3.7% of cases in 2013/14: triple the reported incidence rate over the decade (with many cases of course not being diagnosed or reported). In the Netherlands data is available for both dementia and mental illness.<sup>1</sup> From 2012-2015 euthanasia cases with mental illness have risen from 14 to 56 with an average annual growth rate of 59%. Reported cases with dementia have risen from 42 in 2012 to 109 in 2015: an average annual growth rates of 37. In addition, the Belgium and Netherlands experience is that safeguards to exclude candidates for euthanasia with mental illness and depression, through psychiatric evaluation, have proved to be weak and ineffective. Few candidates were referred and of those referred it was difficult to be objectively clear whether someone had mental illness or clinical depression. The Bill is substantially based on the model applied in Oregon State in the US. The safeguards for the mental illness cohort reflect the safeguards in the Oregon model. However, in this model only from 1998 to 2012, on average only 6.2% of patients who died under the Act in Oregon had been referred for counselling to check for “impaired judgment.” In 2013-2016 this declined to less than 4%. Of 108 patients who died under the Act in 2007 and 2009, none was referred for psychological evaluation.<sup>2</sup> This is a very low level of review.

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<sup>1</sup> Dutch Regional Euthanasia Review Committee: Annual Reports various years.

<sup>2</sup> <http://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/OR-and-WA-Safeguards-FACTSHEET.pdf>, p.2.

In summation the safeguards for applicants for mental illness under the Bill appear to be no stronger than those in the European or US jurisdictions. In these jurisdictions they are clearly weak. In relation to the cohort of applicants with mental illness the Minister's statement of compliance with the Charter seems in conflict with research and available data on the application of PAS regimes overseas. Furthermore, s10(c) of the Charter states that a person must not be 'subjected to medical ... treatment without his or her full, free and informed consent'. The evidence stated from medical experts and the low levels of psychological review in overseas jurisdictions highlights the difficulties in assessing informed consent for the mental health cohort of applicants under the VAD. Compliance with s10(c) of the Charter is therefore open to question.

- **Concerns for persons of linguistically diverse and indigenous background.**

People in these cohort can find it very difficult to understand the intricacies of a complex legal framework that would apply in the proposed assisted suicide regime. There is a real concern that language barriers or poor literacy could lead to a frustration of informed consent under the proposed regime. S10 of the Charter emphasises the need for informed consent. For the sake of prudence, s10 should be strictly interpreted. The Minister has not fully informed the Parliament as to how informed consent will be secured for persons of a linguistically diverse background or persons with limited literacy. S13 and s21(1) of the Charter have been invoked by the Minister to support the Bill. For a free choice to be effectively made language and cultural barriers need to be adequately dealt with. The Minister in her Statement of Compatibility with the Charter has not addressed this issue and makes no reference faced by these important cohorts of potential applicants under the VAD.

- **Concerns for people with disability**

Persons in this cohort facing a terminal illness of significant duration face extraordinary struggles which few of us can even imagine. There is a real risk that the assisted suicide process could exacerbate a co-morbid condition of latent depression or mental illness, with risks that persons with disability with ultimately terminal conditions might activate the assisted suicide process in an episodic moment of depression or anxiety. The other argument, for those with disability is the fear that doctors may consider their life not worth living because of their disability and offer them PAS instead of sound medical treatment.

There is much uncertainty about whether people with degenerative disability can or should access PAS. In the Bill disability alone does not provide access to the measures proposed. The condition of persons with degenerative disability is usually terminal but it is very difficult to predict their longevity. The boundary between degenerative disability and the cohort of persons eligible for PAS under the Bill is unclear. On one hand, the Government offers all reasonable and necessary support to these people under the NDIS and on the other it offers them a lethal drug – two opposite policy approaches. This is an area in which the Bill lacks precision, causes uncertainty and policy confusion.

A pivotal issue in Tasmania and South Australia that led to the failure of proposed legislation was the problem of dealing with the issue of disability. There was uncertainty as to whether disability should be an eligible ground for access to assisted suicide.

In South Australia, the bill introduced by The Hon. Duncan McFetridge MLA included a clause that said that access to the proposed process could not be made on the basis of disability alone. This was seen as being ineffective given that many people with disabilities have co-morbidities that flow from

degenerative conditions. The failure to properly identify the scope of the Bill in relation to persons with degenerative disability was a critical element of the failure to secure passage.

The same problem occurred in Tasmania in 2013. There the Bill included the clause:

*11 (2) For the avoidance of doubt, a person does not have an eligible medical condition solely because of the age of the person, any disability of the person or any psychological illness of the person.*

The Tasmanian Law society indicated inconsistency with these provisions and definitions of disability under Tasmanian law.

This issue is not resolved in the VAD. There is no certainty as to the boundary conditions of access to the Victorian scheme for persons with degenerative disability where the condition is ultimately terminal. This is a critical issue which has been sidestepped. It needs to be resolved for the sake of those with these conditions. Failure to adequately address this issue presents another basis of concern in relation to the Minister's Statement of Compliance with the Charter. In relation to the requirements of s13 and s21(1) of the Charter the Minister argues that the Charter requires that the free decision of a dying person in relation to their end of life choice should be protected. However, the uncertainty in relation to the scope of the Bill for persons with degenerative disability which is terminal deprives these persons of the capacity to make such a decision. The capacity of persons with degenerative disability to access the VAD needs to be clarified before any adequate assessment can be made of compliance with the Charter for persons in this health cohort. Until, this clarification is made a significant question lies in relation to the compliance with the Charter for this critical cohort.

- **Concerns in relation to elder abuse**

The report by the Australian Law Reform Commission (ALRC) in relation to elder abuse used data from the World Health Organisation suggesting that elder abuse can occur in 2 to 14 percent of relevant cases. (Australian Law Reform Commission, Elder Abuse –Final Report p.17, referring to WHO publication The Toronto Declaration on the Global Prevention of Elder Abuse.) <https://www.alrc.gov.au/publications/elder-abuse-report>.

Elder abuse can take many forms through subtle emotional pressure, to direct coercion. In the analysis of public policy decisions that have financial implications for individuals, there is a need to examine the incentive structures that are in place. In the case of the situation of a vulnerable person experiencing a terminal illness, the incentives of the suffering person and the beneficiaries of their estate are in direct conflict. The beneficiaries, usually family members, have a strong financial incentive to expedite release of assets that might flow from a will. The interests of the suffering persons are protected when they are relieved of any emotional pressure, or sense of guilt for still being alive, or of holding up the financial benefit they will provide when they die to the people they love. It is a complex emotional situation, and one that is very difficult to manage through a regulatory regime.

There is an important issue of gaining consent from older Australians.

The prevalence of cognitive impairment also increases with age. From age 65, the prevalence of dementia doubles every 5 or 6 years. 30% of people aged over 85 have dementia ...

This data seems to indicate that high levels of safeguards are required to prevent elder abuse. The Bill relies upon criminal sanctions to prevent coercion to mitigate against the risk of elder abuse. It is argued that full compliance with the Charter requires more than this. Where such sanctions are

applied overseas they are rarely activated and the burden of proof is high. It is argued that such sanctions will be unlikely to be legally effective. The Bill would more fully comply with the Charter if more pro-active intervention mechanisms were facilitated where the risk of elder abuse was deemed high, possibly involving mandatory reporting by social workers in hospital environments in suspected cases of elder abuse.

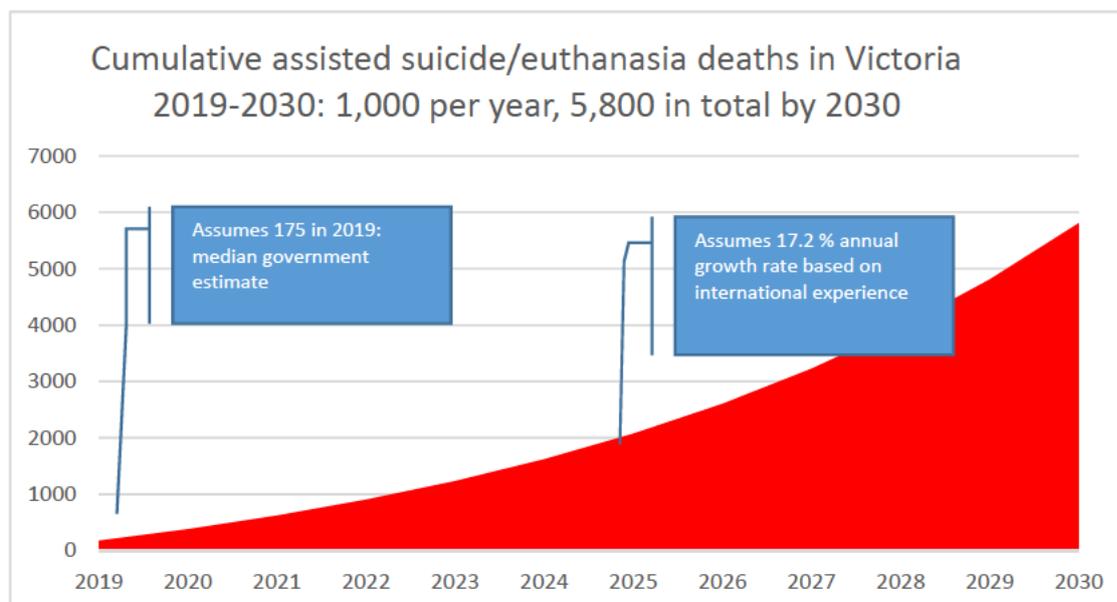
- **Statistical evidence in relation to the efficacy of safeguards in relevant overseas jurisdictions.**

Data in relation to the growth rates of deaths under PAS procedures in relevant international regimes reveals very concerning trends. Research by this author has indicated that these growth rates on average are approximately 17% per year on average.

Country	Initial PAS cohort	Latest data	growth rates
Belgium	235 (2003)	2012 (2015)	19.6
The Netherlands	2331 (2008)	5516 (2015)	13.1
Switzerland	50 (1998)	836 (2014)	19.2
Oregon	16 (1998)	132 (2015)	13.2
Washington State	64 (2009)	170 (2014)	21.6

Source: [http://www.parliament.vic.gov.au/images/stories/committees/SCLSI/EOL\\_Report/LSIC\\_58-05\\_Text\\_WEB.pdf](http://www.parliament.vic.gov.au/images/stories/committees/SCLSI/EOL_Report/LSIC_58-05_Text_WEB.pdf), pages 397-398.

Applying these growth rates to the Victorian initial estimate of 150-200 persons per year in 2030 1,000 Victorians would be expected to end their lives under the regime.



Source: Dr Brendan Long, Australian Centre for Christianity and Culture, Charles Sturt University, 2017.

Looking at the statistics alone, it is difficult to avoid the conclusion that there has been significant scope creep in PAS regimes overseas. The originally intended restrictions on access to PAS through safeguards mechanisms have not proved to be effective. Average growth rates of 17% per annum cannot be explained by the increasing of the age of the population or by administrative amendments made to access the regimes. The data simply evinces the strong conclusion that in the international experience the safeguards have not been proved to be effective. This data tends to undermine the claim of the Minister in her compliance statement that the Bill is consistent with the Charter under s9 due to the mandating of safeguards. The safeguards in the Bill are not radically different to those that have been ineffectively applied in relevant overseas jurisdictions.

- **Concerns of medical professionals**

Medical professionals engaged in end of life medical treatment, palliative care doctors and nurses, generally are very uncomfortable with this proposed medical procedure.

The AMA has stated its position in November 2016:

“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.”

<https://ama.com.au/system/tdf/documents/AMA%20Position%20Statement%20on%20Euthanasia%20and%20Physician%20Assisted%20Suicide%202016.pdf?file=1&type=node&id=45402>

There is also some concerning international experience in this area.

- In Canada's Ontario province, in the eight months between when assisted suicide was legalised (June 2016) and February 2017, 24 doctors had their names permanently removed from a voluntary referral list of physicians willing to help people die. Another 30 put their names on temporary hold. This was at least partly due to psychological distress, the weight of the act of helping someone deciding to end their life and legal ambiguities involved.
- In a telephone survey of randomly selected United States oncologists who reported participating in euthanasia or assisted suicide, 24% regretted participating, and 16% of the physicians reported that the emotional burden of participating adversely affected their medical practice. (E. J. Emanuel et al., The Practice of Euthanasia and Physician-Assisted Suicide in the United States: Adherence to Proposed Safeguards and Effects on Physicians, 280 JAMA 507, 507 (1998).)
- The first cases of legal PAS in Oregon occurred in 1998. In 2000, 35 Oregon physicians were interviewed regarding their responses to PAS requests. Mixed feelings were expressed by the physicians. The authors noted: "Participation in assisted suicide required a large investment of time and had a strong emotional impact . . . Even when they felt they had made appropriate choices, many physicians expressed uncertainty about how they would respond to requests in the future”.

Medical professionals in Victoria are the strongest practical servants of the Charter in relation to medical issues. That medical professionals do not support the VAD seems to speak against the claims of the Minister that VAD is consistent with the Charter in relation to s9,10,13, and 21(1).

- **The shortfall in funding for palliative care in Victoria**

The Parliament, through a rigorous Legislative Council Inquiry process, has identified gaps in palliative care. This was the prime focus of the Legislative Council inquiry report. Of its 49 Recommendations, 29 Related to expansion of service delivery in palliative care, 19 to issues related to the process of Advance Care Planning directives to better manage end of life choices for the patient, and only one recommendation was made in relation to physician assisted suicide.

Palliative Care Victoria (PVC) conducted a recent survey which “found over 92% of Victorians support more government funding for palliative care.”

PVC has also stated that there is a \$65m a year funding shortfall needed to deal with unmet need and increasing demand for palliative care services. <http://www.pallcarevic.asn.au/2017/07/funding-increase-needed-improve-access-palliative-care/>

It can be argued that the Charter implicitly embodies a right to fully funded palliative care service delivery. The Minister has argued that the Charter embodies a right to personal autonomy which is to be taken as being included in the rights provided for in the Charter in s21(1). Although such an expansive interpretation of s21(1) is contested, were it to be accepted, it would seem also to involve a right to adequate service delivery in palliative care. Only if such services are adequately funded can the rights of personal autonomy in decision making in end of life choices be really protected. Any argument that the VAD protects the rights of individuals to a free choice on end of life issues seems moot until the prevailing choice – that of accessing adequate palliative care services – is guaranteed through adequate funding. Until the funding shortfall for palliative care services is addressed it can be argued that the Minister’s statement of compliance for the Bill in relation to the Charter is deficient. It is argued that any Bill in relation to end of life choices that is not accompanied by a budget decision to fully fund palliative care services required by the Charter fails to meet the standards set by the Charter.

- **Questions in relation to the interpretation of s13 and s21(1)**

There are also grounds to assert incompatibility of the VAD with the Charter in relation to s13 and s21(1) of the Charter. S13 relates to the question of privacy and reputation. On a plain reading, the provision is intended to protect private information and reputation. However, the Minister in her compliance statement indicates that:

The fundamental values which the right to privacy protects include physical and psychological integrity, individual and social identity, and the autonomy and inherent dignity of the person. In my view, the bill promotes the right to privacy by allowing Victorians who are suffering at the end of their life, in very limited circumstances, to choose to end their life according to their own preferences.

The mischief s13 seeks to protect is the abuse or theft of personal information. To interpret this section of the Charter as permitting a person to choose a specific medical procedure (PAS) over another (palliative care) is a courageously expansive reading of the scope of s13. On the surface such an interpretation of s13 is not sustainable.

S21(1) of the Charter states ‘Every person has the right to liberty and security’. The Minister in her Statement of Compliance with the Charter states “The right to liberty and security of the person also encompasses the principle of autonomy”. However, it is clear that s21 relates to freedom from unjust or unlawful detention. To justify this very exceptional reading of s21 the Minister is candid that she relies on the decision of the Canadian Supreme Court, which she states:

... has held that a prohibition on voluntary assisted dying contravened the right to life, liberty and security of the person, which were all taken to relate to autonomy and quality of life.

Judgements of the Canadian Supreme Court on this issue are extraneous to the interpretation of s21 of the Charter in Victoria and cannot be taken to fundamentally redirect the purpose of s21 of the Charter to encompass a principle (the right to medically assisted suicide) that is clearly outside its clear statutory intent (unlawful detention).

It is argued that the Minister’s interpretation of s13 and s21(1) is essentially speculative. Such speculation is not in the public interest as it distorts the meaning plainly intended under these sections of the Charter.

## **Conclusion**

It is argued that there are deficiencies in the Minister's Statement of Compliance for the VAD with the Charter in relation to the efficacy of safeguards proposed in the Bill. It is argued that the VAD should not proceed for consideration of the Parliament until fundamental human rights concerns listed above are addressed or alternatively should be addressed in the Parliament's consideration of the VAD.

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October 2017