

VOLUNTARY ASSISTED DYING BILL

Second Reading

Adjourned debate on second reading.

(Continued from 2 December 2020.)

The Hon. S.G. WADE (Minister for Health and Wellbeing) (17:42): I rise to speak on the Voluntary Assisted Dying Bill 2020. I advise the council that this bill is a conscience vote for government members and accordingly I speak for myself alone. I have not supported any of the euthanasia bills that have come before the parliament since I was appointed to the Legislative Council in 2006. While I will be supporting the second reading of this bill I will consider my position on the third reading after the completion of the committee stage.

I do not come to the bill with a fundamental opposition to euthanasia. I would describe myself as a person who is conservative on euthanasia rather than a person who is opposed to euthanasia in principle. As a liberal, I accept the right of every individual to personal autonomy, including the right to make end-of-life decisions. While my Christian faith teaches me that euthanasia is not an option for me, in a pluralist society other people will hold differing views and should have the freedom to live their lives according to their values and their moral codes, as long as their actions do not cause harm to others.

Society, and each individual within it, has a strong interest in making sure that euthanasia does not become a cloak for murder. As a House of Lords Select Committee on Medical Ethics put it in 1994, 'Society's prohibition on intentional killing is the cornerstone of law and of social relationships.' The prohibition protects each of us impartially, embodying the belief that all are equal. By acts of omission and acts of commission people can already act to hasten their own death. People can already choose to do so by not taking food and drink, by not consenting to necessary medical treatment or by taking their own life by other means.

Voluntary assisted dying is fundamentally different because it involves the state allowing certain third parties to hasten death directly or indirectly without fear of action being taken against them. In considering this bill, we need to ask ourselves whether it is reasonable for a citizen to expect that the state will take active steps to support them to hasten death.

Of course, the key factor that turns assisted suicide or voluntary assisted dying into murder is the will of the person who dies as a result of the act. The first test for any euthanasia legislation is whether it provides strong confidence that medical assistance in dying will not be administered without the consent of the subject. Are we sure that the person who will die as a result of voluntary assisted dying wants to die? We also need to be sure that the intention is enduring. We want to protect people from transient desires. This bill puts in place a process that in my view provides sufficient assurance that the person's intention to terminate their life is clear, voluntary and enduring.

The desire also needs to be well founded. I do not consider that it is reasonable for a citizen to expect that the state will take active steps to support them to hasten their death in any and every circumstance. This bill says that the state will only provide voluntary assisted dying in the context of imminent death. The person needs to be in the last six to 12 months of a terminal illness. Previous bills put before the South Australian parliament have proposed too broad and subjective tests for eligibility. In my view the threshold in this bill is sufficiently clear and appropriately narrow.

Since the parliament last considered euthanasia legislation the context has fundamentally changed. If the Parliament of South Australia had passed previous bills, we would have been the first jurisdiction in Australia to have legislated for voluntary assisted dying. If we pass this bill, we are likely to be joining four other states who are moving to legally allow voluntary assisted dying. Three of those states have already legislated, and Queensland is well advanced.

This changes the context of our deliberations, because we now need to consider issues of equity of access to health services. Not putting in place a voluntary assisted dying regime would deny South Australians access to a health service which is becoming available to a majority of Australians. Let me be clear that access is a factor; it is not determinative. In my view, it is better not to have access to a health service than to have access to the service under a flawed law.

The changed context—the wave of voluntary assisted dying legislation in a relatively short period—also gives our nation an unprecedented opportunity to establish nationally consistent legislation in a very sensitive area of health law. The voluntary assisted dying laws enacted or emerging in other states are very similar to each other, drawing in particular on Canadian legislation. They are so similar that I think it is fair to describe all of them as reflecting the Australian model.

The Australian model of voluntary assisted dying laws shares a number of core elements. The Queensland Law Reform Commission summarised those elements as follows:

- eligibility requirements that limit access to competent adults with a diagnosed disease, illness or medical condition that is advanced and progressive, will cause death and involves intolerable suffering;
- limitations on access to voluntary assisted dying based on the adults' voluntary and enduring requests;
- independent assessments of eligibility by two suitably qualified and experienced medical practitioners;
- the right of conscientious objections by health practitioners;
- providing for self-administration of a voluntary assisted dying substance or, in limited circumstances, administration by a medical practitioner;
- oversight provisions including reporting obligations, monitoring by a review board and tribunal review of certain decisions; and
- a period after enactment but before commencement of the legislation to prepare for implementation.

I think it is helpful for patients, for clinicians and for regulatory bodies if the laws in an area of law such as this are similar across Australian jurisdictions. Consistency would support access, it would support quality and safe practice and it would reduce the pressure for what is sometimes called medical tourism.

I support South Australia joining our sister states in enacting the Australian model of voluntary assisted dying. In that context, I want to be clear on my general stance in relation to amendments. I think that the basic framework of the bill is sound and should be supported. I think there is significant value in national consistency of voluntary assisted dying legislation.

Accordingly, I indicate to the council that I will only support amendments to the bill that do not undermine close national consistency, and I will not support the third reading of the bill if the bill is amended in committee in a way that does not maintain close national consistency. The sponsors of this bill may well get majority support for this bill without my support, but they should be in no doubt that I will not support the bill at the third reading if significant changes are made.

Within the Australian model, different jurisdictions have made different calls on what I would call secondary issues, for example, whether to allow the use of telehealth. I am willing to consider amendments on secondary issues, but I am not willing to consider amendments that amend the primary elements of the model. Further, I am open to amendments that adjust the Australian model for the South Australian context. As the Queensland Law Reform Commission put it:

Caution is required in drawing comparisons and guidance from legislation adopted in jurisdictions with different legal and health care systems.

It goes on to state:

It is also important to ensure that the draft legislation is well adapted to Queensland's specific needs.

That statement is just as true of South Australia. One area where I think the bill does need to be adapted is to clarify the relationship between restorative care, palliative care and assisted dying. In particular, this is important in South Australia. In my view, we have superior legislation supporting consent to medical treatment and palliative care, and I would not want this bill to undermine that law.

If I could beg the forbearance of the council, I would like to quote a relatively large section of the recent University of Tasmania report that addressed the legal status of the double effect principle arising in palliative care. The report stated:

Elsewhere in this report (Section 6.6), consideration has been given to the provision of palliative care in Australia and its relationship with VAD. For the purposes of this analysis, the focus is on the legal status of the doctrine of double effect in Australia with the aim of differentiating this from VAD.

The doctrine of double effect, which had its origins in moral theology, recognises that palliative medication administered to a patient with the intention of relieving pain and symptoms will be lawful even if that will have the unintended effect of hastening the patient's death.

Central to this doctrine is the focus on intention: provided the primary intention is to relieve pain and symptoms rather than to cause death, the doctrine holds that the medical practitioner or other authorised person administering palliative medication will not be criminally liable even where death was foreseen.

Based on the circumstances of the cases where this doctrine has been relied on, it is generally understood that the doctrine of double effect only applies to a person who is near death.

Palliative medication administered to a patient with the intention of relieving pain but which may hasten death is an accepted part of medical practice.

It is important that this is clearly differentiated from VAD, which involves the intentional assistance to bring about death at the request of the patient.

The critical distinction is intention; for palliative medication, the intention of the medical practitioner is to relieve pain, not to cause death. The consent of the patient is not a prerequisite; indeed, the patient may not be in a position to consent. VAD, by contrast, involves the deliberate and intentional bringing about of the death of the patient at the patient's clear and explicit request further to the detailed substantive and procedural legislative requirements.

Whilst the doctrine of double effect is supported by case law in the UK (Adams Case) and other common law jurisdictions, there is no Australian authority directly on this issue. However, South Australia, Queensland and Western Australia have legislated to clarify the law in this area, providing that authorised persons who provide palliative medication will not be criminally liable provided that certain criteria specified in the legislation are met. Under the legislation of Queensland and Western Australia the palliative medication must have been provided in good faith, with reasonable skill and care, and be reasonable having regard to the person's state at the time and in the circumstances of the case (Criminal Code (Qld) s282A; Criminal Code (WA) s259). The South Australian legislation requires additionally that the person is in the terminal phase of a terminal illness and that the palliative medication is administered with the consent of the person or their representative (Consent to Medical Treatment and Palliative Care Act 1995 (SA) s17).

Further, the University of Tasmania report states:

In conclusion, even though practices that constitute this double effect and VAD are distinctly different, perhaps because of this very difference, legislation could be considered to clarify the double effect issue.

I advise the council that I intend to develop a set of amendments to seek to support the integrity of palliative care by differentiating it from assisted dying and protecting South Australia's laws on double effect. Current health law and practice, in particular in palliative care, in my view would benefit from enhanced clarity. Clinicians, patients and their families often conflate palliative care, double effect and euthanasia. This bill may also provide an opportunity to provide clarity. I also indicate that I am yet to consider possible further amendments.

I must admit that I am uncomfortable that this bill has not been the subject of detailed legal analysis in South Australia. Tasmania recently released the report commissioned by the University of Tasmania before they legislated. Queensland has commissioned a report from the Queensland Law Reform Commission, which is due to be finalised by 10 May. I would prefer that the committee stage of this bill did not progress until the QLRC report is available, but I will not be insisting on that. In conclusion, I reiterate that I will be supporting the second reading, I look forward to the committee stage of the bill, and I reserve my position on the third reading.