



**CONSULTATION ON THE PROPOSAL FOR
VOLUNTARY ASSISTED DYING**

**SUBMISSION TO
THE PREMIER, LARA GIDDINGS,
AND THE LEADER OF THE GREENS, NICK
MCKIM**

MARCH 2013

SUMMARY

Dying with Dignity Tasmania is in very strong in-principle support of your proposal for voluntary assisted dying legislation, as set out in the consultation paper released on 3 February 2013. We congratulate you and thank you for your ongoing commitment to this very important social law reform. We commend you in particular for basing your proposal on key principles and values, thorough research and quality evidence and well-reasoned arguments. This approach is in stark contrast with the material being put forward against the proposal which has included very poor quality data and major errors in reasoning, including inaccuracies, irrelevant arguments and piecemeal 'cherry-picking' of minor details instead of addressing the key issues and arguments.

We are recommending some minor changes which we believe will make the proposed legislation more effective and compassionate. We trust you will support them because they are in keeping with the principles and general rationale for your proposal.

It is now very clear from extensive evidence that the public and parliamentarians can be confident that voluntary assisted dying legislation is needed, that it is safe and, in fact, safer and more responsible than allowing very unsatisfactory aspects of the current situation to continue. When the legislation comes up for debate in Tasmania later this year, it will be the first time that parliamentarians will have such a high level of assurance that assisted dying legislation is not a threat to vulnerable people in our community and that risks can be overcome with careful safeguards. They can be confident that it is responsible to vote for the legislation, and also to act with compassion, ensure the law keeps up with community changes and to act in a way which is consistent with the views of the vast majority of the community.

There has now been intense scrutiny of experience of legislation elsewhere for many years and that has resulted in overwhelming evidence that doctors are implementing the legislation carefully and responsibly. There is every reason to assume that Tasmanian doctors will behave as responsibly and compassionately. This evidence, and recent highly respected and thorough reviews, combined with the material in the consultation paper and in responses to the consultation, will provide Parliamentarians with the standard of information and arguments that they need to make a well-informed and rational decision on the voluntary assisted dying legislation when it comes before the Parliament later this year.

This submission includes:

- general comments
- comments and recommendations on specific issues
- additional information
- examples of flaws in the criticisms of the proposal
- conclusion.

GENERAL

- Dying with Dignity Tasmania is in very strong in-principle support of the proposal for voluntary assisted dying legislation set out in the consultation paper released on 3 February 2013. We recommend a few changes that are in keeping with the principles and general rationale for the proposal and which we believe are necessary to meet the needs of more people with great suffering who should also be able use the provisions of the legislation as a 'last resort' option.
- We recognise the very well argued case you have put forward for the limited and responsible legal option you propose, and thank you for recognising that the proposal does not go as far as some people will want. That is the case for some of our members. However, we believe that with some minor changes the proposal would be improved considerably, both as a compassionate option for those with great suffering that cannot be relieved adequately and in keeping with an approach that puts the needs of those who are dying with great suffering at the heart of this debate.
- We strongly endorse:
 - your view that there is a compelling case for law reform in relation to voluntary assisted dying and that this is provided through a number of arguments which **together** make that case
 - the principles and values of compassion, respect and tolerance of different views and choices that underpin the proposal and which are set out in section 2.3 and reiterated and amplified in different ways through the consultation paper
 - your commitment to act on those principles and values, not just pay 'lip-service' to them
 - the fact that the proposal is consistent with the views of the vast majority of the population, including the vast majority of those with religious convictions. (See below some additional information on the 2012 Newspoll which confirms many other poll results.)
 - the fact that the proposal is well supported by thorough research and quality evidence, which will contribute to a well-informed and rational basis for decision-making on this issue in the Parliament, and which shows that yours is a safe and responsible approach
 - the logical and carefully reasoned arguments for each of the proposed details of the proposed legislation.

- In particular, we note and support:
 - the use of the term, 'voluntary assisted dying', rather than other terms that have become very confusing because of the different definitions. We are particularly supportive of your use of the terms self-administered and doctor-administered assisted dying which is in keeping with expert psychological opinion.¹
 - your commitment to palliative care, which we share, and the information and expert advice you include in the paper that some people will have great suffering that cannot be relieved adequately "no matter how skilled and caring the medical and palliative care professionals are". As Professor Michael Ashby has said, and you quote on page 16, "palliative care has limitations and it must be acknowledged that the best efforts of multi-disciplinary palliative care services do not always provide patients with what they wish or need".
 - The evidence that, in those places with voluntary assisted dying legislation, there has been no undermining of the wonderful contribution of palliative care to many people's end-of-life care and comfort or an impediment to the ongoing development of palliative care services. Rather, in the view of Justice Smith in the judgement, *Carter v Canada*, "on the contrary, palliative care provision has been improved since legalization by some measures" (p15)
 - your commitment to address the needs of those with great end-of-life suffering that cannot be relieved adequately even though there are only a few of them.
 - the recognition that voluntary assisted dying will always be rare (eg only 1 in 500 deaths in Oregon is due to assisted dying, 2 per 100 in Belgium and under 3 per hundred in the Netherlands)
 - the value you place on personal autonomy within the context of "the value and importance of a tolerant democratic society and the rights and freedoms it provides for all of us when it comes to making decisions about matters involving our fundamental beliefs". We agree with the quote in the paper (p 8) that: "It is unreasonable, inhumane and patronising ... to insist that a few people should suffer extreme distress and indignity because society 'values their lives' - regardless of how meaningless those lives have become to their owners". A critically important issue of principle for MPs when considering the proposed legislation is not whether they support voluntary assisted dying per se but whether they support people's right and freedom to make choices for themselves in a regulated and safeguarded environment taking into account all their circumstances, beliefs and values, and co-operating with their doctor/s to find the best option for them. This also shows respect for doctors and the doctor-patient relationship.
 - the proposal that if we must have a residency requirement, then it should be the same as that for the electoral roll

¹ See for example Washington State Psychological Association guidelines which support such value-neutral terminology because "the term 'suicide' implies psychiatric illness or other emotional distress that impairs judgment and decision-making capacity, and thus may not be an accurate or appropriate term for a terminally ill, mentally competent individual choosing to control the time and manner of his or her death".
<http://www.wapsych.org/displaycommon.cfm?an=1&subarticlenbr=252>)

- the family notification policy that recognises the reality, supported by evidence from the research findings of Professor Onwuteaka-Philipsen, that “it is common for a patient’s family to disagree with a patient’s wish to have an assisted death” and that families are not putting pressure on patients to make a decision to access assisted dying, but instead the “pressures on individuals commonly work in the opposite direction: it is often the patient’s family who does not want the patient to die” (p58 -59).
- The sound intellectual and values basis for your proposal stands in stark contrast to the flawed case being put forward in the media and on websites by those opposed to assisted dying law reform. In general, the critics of the proposal have failed to address key issues and arguments in the consultation paper and have continued to maintain what can only be described as a ‘fear-mongering’ campaign without substance or credibility.

Their commentaries have demonstrated many of the flaws which are identified in section 3.1 of the paper as resulting in unreliable and invalid claims and arguments which do not meet the standards required for decisions on our laws. The flaws we have noted involve dependence on very poor quality data and major errors in reasoning, including lack of evidence for claims, ill-informed speculation, absence of critically relevant information, unsubstantiated fears and concerns, repeated inaccuracies, out of date and irrelevant information, ‘cherry-picking’ and piecemeal data which provides a distorted picture, perceived ‘cause and effect’ when no such relationship exists, inconsistencies and contradictions, and dependence on unreliable and biased sources, including citing only those people of the same religious persuasion and views. We refer below to a number of commentaries of particular concern. We will be interested to see the detailed submissions made to the consultation by the individuals and organisations concerned in order to undertake a detailed analysis to provide to MPs and to include on our website in coming months.

SPECIFIC ISSUES AND RECOMMENDATIONS

Key DwDTas Issues

1. Consultation point: Should patients with non-terminal yet progressive illnesses be eligible for an assisted death?

Recommendation: We strongly recommend an extension of eligibility for voluntary assisted dying to those people with non-terminal yet progressive and incurable illnesses who meet all the requirements of the ‘terminally ill’ definition in the proposal, except for the fact that their condition is not reasonably expected to cause their death.

Rationale:

We make this recommendation for a number of reasons:

- 1.1 We believe that extending eligibility in this way is in keeping with principles and rationale you provide for your proposal, chiefly compassion and providing a last resort option. There

are many statements you make in the consultation paper, and have made at other times, that indicate that you both feel, and want to act on, compassion for those with great suffering at the end of their lives and for whom assisted dying may be the only way for their suffering to be brought to an end.

- 1.2 We are concerned that someone in the same situation as Elizabeth Godfrey may not be eligible for assisted dying under the proposed legislation unless there are changes to the criteria related to the person's condition to include 'non-terminal' but incurable and progressive diseases. We understand that it was always intended that someone in a similar situation to hers would be eligible and your intention needs to be put beyond doubt.

We believe she would have met the requirement to be in "the advanced stages of an incurable and progressive medical condition" which, as stated in the paper on page 39, "will include the situation where the patient's condition has advanced to the stage where the medical treatment reasonably available to the person is unacceptable to him/her or is confined to palliation to provide relief from pain and other distressing symptoms". We believe she would also have met the requirement where she and treating doctors would need to "come to the conclusion that that there is no reasonable alternative to improve [her] condition and to relieve [her] suffering adequately and to [her] satisfaction". However, there is now some doubt that her condition would have been expected to cause her death, at least within an identifiable timeframe.

For all intents and purposes, Elizabeth Godfrey was 'at the end of her life' and was merely 'existing' because of her suffering and because she had none of the quality of life that she valued. We believe there is a very strong case for anyone in a similar situation to be eligible for voluntary assisted dying providing they meet all the other stringent requirements.

- 1.3 The difficulty in determining whether Elizabeth Godfrey's medical condition would have been expected to cause her death could have been made more difficult by the fact that, like many people nearing the end of their lives, she had a number of different chronic conditions rather than one disease that could clearly be deemed 'terminal'.

An article in the Medical Journal of Australia on 4 March 2013 makes a number of important points about chronic disease that are relevant to the issue of eligibility for voluntary assisted dying, including that chronic disease is "a growing 'epidemic'" that "accounts for more than half of all Australian deaths". With chronic disease, prognosis may be ambiguous or unknown. Other points made in the article are that "many people with chronic disease have multiple comorbidities" and chronic diseases "while usually not immediately life threatening, are the most common and leading cause of premature mortality".²

² Burgess TA, Braunack Mayer AJ, Crawford GB, Beilby JJ. Meeting end-of-life care needs for people with chronic disease: palliative care is not enough *Med J Aust* 2013; 198(4): 186

An increasing number of people will therefore be in a similar situation to that of Elizabeth Godfrey and we believe very strongly that the proposed legislation must take their characteristics into account if it is to provide the most suitable model for the Tasmanian situation. It could be a major dilemma for doctors who wish to assist them, because they are clearly in a terrible situation and have exhausted all other reasonable options, but it is difficult to be sure if their conditions could reasonably be expected to cause their death. We believe the most compassionate and reasonable approach would be to make it clear that those with non-terminal conditions would be eligible for access to assisted dying if they meet all the other requirements of the definition of 'terminally ill' as proposed.

1.4 There are major difficulties in people with chronic disease rather than a terminal disease like cancer in accessing palliative care. Burgess et al state: "Originally, palliative care developed to provide support for people dying with cancer, with a trajectory of relatively predictable deterioration requiring intensive support over a fairly short period of time. Chronic disease tends to follow a much slower and more unpredictable trajectory that includes progressive functional decline, poor quality of life and increasing dependency on both formal and informal caregivers as well as the health system."

They also make it clear: "often this process is poorly handled, and general practitioners and primary care clinicians are left to manage an uncoordinated and challenging situation. Inadequate and inappropriate end-of-life care has significant and costly implications: unnecessary hospitalisations; prolonged intensive interventions in acute care settings; patients dying in intensive care units rather than in their preferred place of death; poor symptom management; little opportunity for patients and their families to discuss issues around death and dying; and increasing stress on staff who are not trained in the provision of palliative care".

2. DwDTas issue: Voluntariness and advance care directives

Recommendations:

- (a) That you note the concern of many people with the growing incidence of dementia and that, as a result, there are many people who support access to assisted dying through a request in an advance care directive;
- (b) indicate that this matter will be the subject of future review.

Rationale: We note your recognition that "dementia is a devastating and challenging illness, both for the patient and their family and carers" and understand your explanation for not recommending that an assisted death could be accessed through any form of advance request, ie, that you "do not have the level of evidence about how to ensure sufficient safeguards, nor do we believe that there has been wide community consideration of, or support for, this option".

However, as you know, this is a matter of great concern and fear as the incidence of dementia in various forms increases in our society and as more people witness the end of life of their

loved ones after significantly prolonged and terrible suffering. If you are unable to make provision in this proposed voluntary assisted dying Bill for access through an advance care directive, for the reasons stated, giving an indication that it will receive detailed future attention would provide some comfort to those who have great fear about their own situations.

3. DwDTas issue: Waiting periods

Recommendations:

- (a) The 14 day 'cooling off' period should commence when the patient has made the written request and not only after both doctors have determined the patient's eligibility;
- (b) There should be a process to allow approval of shorter waiting periods in exceptional circumstances.

Rationale:

For both these recommendations, the underpinning principles are the importance of patients being able to live as long as possible and to be able to make a decision about requesting assisted dying as a 'last resort'.

- (a) The purpose of a 'cooling off' period is to ensure that the **patient** is not acting in haste and therefore the time period should be related to the **patient's** decision and action and not to any actions by the doctors involved. The 14 day period should start from the date of the patient's written request which is an important statement of serious intent after an oral request has been made and discussed. It should run concurrently with the process involving the doctors' consideration of all the required matters. To do otherwise could be to open the process to an unacceptable and unnecessarily prolonged delay for the patients who may well be in a very difficult situation by the time they decide that this is the only option remaining to them to end their suffering and to achieve a death they regard as dignified.
- (b) We are mindful that for some people a sudden worsening of their condition may lead to unexpected suffering or worsening of their suffering to the point where it has become unbearable and unrelievable. There should therefore be provision for shorter waiting periods in exceptional circumstances. There still needs to be evidence of persistence and consistency in the patient's request for an assisted dying option. We believe the best way of providing for shorter waiting periods in a safe and responsible way is to have a process for urgent applications to the independent monitoring body (see section 5.17) for approval and for that body to develop clear guidelines, criteria for and reporting of such approvals.

4. DwDTas issue: Consulting doctor issue

Recommendation: We recommend that the treating doctor provide his/her conclusions and report to the consulting doctor.

Rationale: Treating doctors will usually have a much longer experience and knowledge of their patients who are making requests for voluntary assisted dying than the consulting doctors. It is

unrealistic, and likely to be time-consuming and demanding on patients, to expect consulting doctors to have to build up that knowledge without the background information and professional opinion of the treating doctors.

Other consultation points

1. Under our proposal, the treating doctors and the patient must together come to the conclusion that there is no reasonable alternative to improve the patient's condition and to relieve the patient's suffering adequately and to the satisfaction of the patient. Should 'unbearable' or 'unrelievable' suffering be included as a separate eligibility criteria?

Recommendation: 'Unbearable' or 'unrelievable' suffering should not be included as a separate eligibility criterion.

Rationale: It is implicit in the proposed requirement that the patient's suffering would have to be unrelievable through any reasonable alternative to assisted dying and this provides an adequate safeguard. It is not necessary to set up an additional and potentially burdensome hurdle for the patient while doctors take a considerable time to determine whether their suffering meets an ill-defined level.

2. Should eligibility be linked to an anticipated life-expectancy?

Recommendation: Eligibility should not be linked to life expectancy.

Rationale: The consultation paper sets out adequate reasons for not linking eligibility to life expectancy. Your view is confirmed by an article in the Medical Journal of Australia of 4 March 2013 which reinforces the point about the difficulty of determining life expectancy: "Medical professionals are notoriously poor at predicting the life expectancy of their patients and find making predictions of this type distressing."³ The authors provide references to two studies supporting this view.

3. Opinion polling consistently shows strong support for a doctor being able to provide a lethal dose of medication to a terminally ill patient. Do you think the patient's attending doctor should be able legally to administer the fatal dose?

Recommendation: The patient's attending doctor should be able legally to administer the fatal dose.

Rationale: We support your rationale for this as set out in detail in section 5.7.

³ Koczwara B. What is futile and who decides? The clinician's dilemma *Med J Aust* 2013; 198(4): 221

4. Should voluntary assisted dying be limited to the patient self-administering the fatal dose? If only self-administered assisted dying is legal, what assistance should be provided to those who are physically unable to commit the act?

Recommendation: Voluntary assisted dying should not be limited to the patient self-administering the fatal dose.

Rationale: We support your rationale for not limiting assisted dying to self-administration, as set out in detail in section 5.7.

5. What provisions should be made for those patients who are physically unable to sign a request? Do you think a video recording of the request would be appropriate? Or should the patient be able to designate someone to sign the request on their behalf as occurs in Belgium?

Recommendation: The patient should be able to designate someone to sign the request on their behalf.

Rationale: This is the easiest and most appropriate option.

6. What are your views on the role of an independent consultation service in a legislated model of voluntary assisted dying?

Recommendation: An independent consultation service could provide a valuable service and enable independent consultations to be done more quickly and effectively.

Rationale: We see value in an independent consultation service, particularly for rural doctors. Treating doctors would not have to hunt around for someone available and willing to provide an independent assessment, which could cause delays for patients who have made a request and also make unacceptable demands on the treating doctors' time and resources.

There is also value in the assurance this service could provide of the standard of independent consultations when very few of them will be needed. It is difficult to build and maintain expertise in such a situation.

Some doctors may be prepared to contribute in this way but would prefer not to be the treating doctor. For example, some doctors may have personal religious convictions against assisting someone to die but still respect the rights of others with different beliefs to have access to a well-regulated, safeguarded system of voluntary assisted dying.

7. Should the consulting doctor have to meet face-to-face with the patient? Is it enough for them to just review the patient's medical record? Could the utilisation of 'telehealth' or 'e-health' technology replace a face-to-face consultation?

Recommendation: It is not enough for the consulting doctor to just review the patient's medical record but the utilisation of 'telehealth' or 'e-health' technology could replace a face-to-face consultation.

Rationale: The 'telehealth' option is the best one for the patient nearing death and with considerable suffering, especially if they happen to live in rural Tasmania and would have to travel a considerable distance for a face-to-face consultation.

8. We are proposing that an independent oversight mechanism be established to monitor and report on the operation of voluntary assisted dying legislation. Do you think this body should take the form of an independent 'committee' (as occurs in Belgium and the Netherlands) or could this monitoring be undertaken by a government department (as occurs in Oregon and Washington)?

Recommendation: We propose that the independent oversight be through a Government department or other body rather than a 'committee' system as in Belgium and the Netherlands.

Rationale: It is important that any monitoring is undertaken by a body that is objective, independent of vested interests and able to report to Parliament. We would expect that professional bodies will adopt policy and guidelines to assist their members in meeting the requirements of the legislation. There would be nothing to prevent them also undertaking their own monitoring, eg to determine information and education needs of the group they represent.

ADDITIONAL INFORMATION

1. 2012 Newspann

The 2012 Newspann results confirm what has been found in many other well conducted and reputable polls. The national poll was of 2,521 respondents conducted by telephone late October through mid-November 2012. Respondents were asked the question: "Thinking now about voluntary euthanasia, if a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering asks for a lethal dose, should a doctor be allowed to provide a lethal dose?"

We summarise below the main findings of the poll and will send to you a longer and more detailed report:

- An overwhelming majority said yes (82.5%), a very small minority (12.7%) said no, with 3.8% 'don't knows' and 1.0% refused.

Support was therefore above the 2007 Newspann results (79.7%) and not significantly different from 2009 results (84.9%). These results are comparable with other research such as a 2010 Australia Institute survey reported January 2011, which surveyed 1,294

Australians. The result is also consistent with public opinion in Europe. A late 2012 ISO Public⁴ study (p6) found overwhelming support for personal end-of-life choice from 71% to 87% across a range of European countries, and a small majority in Greece (52%). A similar majority said they would consider assisted dying if faced with a serious incurable illness (p8).

None of these results are as high as the support in the Netherlands, which is the country with arguably the most experience of voluntary assisted dying and where the population has had the greatest opportunity to judge the effectiveness of safeguards and the safe and responsible implementation of the law by doctors. As you report in the consultation paper (p 8), the Royal Dutch Medical Association gave evidence to the Commission on Assisted Dying in the UK in 2011 that 92% of the population in the Netherlands support their euthanasia law and 84% of physicians have either performed self-administered assisted dying or doctor-administered assisted dying or are willing to do so.

- The 'yes' response was similar across States. There was 78% support by the Tasmanian respondents (app 200) which is the same as that in the EMRS survey of 1000 Tasmanians conducted for the Greens in 2009.
- There was very little difference between men and women in their responses and support was very high amongst all age groups, but especially high amongst those aged 50 -59 (88%).
- The 2012 poll confirmed what the 2007 poll had found about the high level of support among those who indicated they had religious affiliations. It also found that nearly nine out of ten (88%) Anglicans and more than three out of four (77%) Catholics who were interviewed for the 2012 poll answered 'yes'. Opposition was highest amongst smaller Christian groups (25%), but overall, even among this group, there was significant majority support (70%).
- The poll found that, even though most Australians with a religion support reform, there is a strong correlation between having a religion and opposition to the question. Of those who opposed it, 81% said they had a religious affiliation whereas 15% did not. Of those who answered 'yes' to the question, 56% said they had a religious affiliation and 43% said they did not.

2. Communityrun Petition

The President of DwDTas, Margaret Sing, started an online petition on communityrun (<http://www.communityrun.org/petitions/support-tasmanian-proposal-for-voluntary-assisted-dying-legislation>) on 6 March 2013. By early on 15 March, it had 670 signatures from Tasmanians and non-Tasmanians. Many of those who signed may also have submitted a submission as part of the consultation process.

⁴ ISO Public (2012), Assisted suicide in the view of Europeans, November, www.isopublic.ch

What has been particularly noticeable about the response is that people have chosen to add extremely heart-felt comments about why they support your proposal for voluntary assisted dying, for example:

- “Watching someone you love dearly have to die a prolonged and agonising death with no dignity left is heart wrenching. I hope legislation is soon passed to ensure others don't have to suffer in the same way as my father had to.”
- “It is vital that people have voluntary assisted dying as an option should they desire to use it. The comfort provided by this availability is immeasurable.”
- “I strongly believe in voluntary euthanasia as I witnessed several relatives deciding to starve themselves to death as there was no other way to die.”
- “I have looked after my mother who had cancer & begged for help to die through months of shocking pain, loss of all dignity or the right to choose but just had to live through it because in our final days after a lifetime of making our own choices now have no rights we are dictated to a minority of self serving extremists & weak Politicians afraid that they may lose a few votes of the self righteous, PS then 2 of my aunts went through the same thing where is the justice?”

We will keep you informed about the petition results and comments.

FLAWS IN CRITICISMS OF THE PROPOSAL

1. Key issues that are not addressed

Those opposing the current proposal generally:

- fail to acknowledge the risks in the current situation where assisted dying is happening anyway but without any regulation, safeguards, monitoring or equity
- fail to acknowledge the negative consequences of continuing the current situation, including, as you say in the paper, people “having to resort to violent methods of suicide as some terminally ill patients currently do”; suiciding too early while they are still able to do it with implicating others but having to do it alone and sometimes without telling loved ones; people starving themselves to death over an extended period or individuals having a terrible death which has effects on their loved ones over many years. (We have heard many instances of all these negative consequences and have encouraged those concerned to include the details of their experiences in their submissions and/or to provide them to us for inclusion on our website, anonymously if necessary as long as we can confirm their reliability.
- fail to acknowledge the significant differences between overseas legislation in different jurisdictions and between any of the existing legislation and the proposal for Tasmania.
- largely ignore the fact that, while palliative care is extremely important, it cannot relieve all suffering adequately for some people and is therefore not an alternative to a legal option of voluntary assisted dying. This is not an ‘either-or’ issue.
- propose alternative options that do not meet the tests of compassion and respect for the free and voluntary choice of the individuals concerned

- fail to demonstrate any respect for the skill, care and responsibility of doctors to make professional decisions in keeping with the law⁵
- use inappropriate emotive and exaggerated terminology and definitions that distort the issue⁶.

2. Dependence on very poor quality data and major errors in reasoning

We respect the right of everyone to their beliefs and values and to express their views on this important issue, but with the right to express our views, there is a responsibility to check claims so they do not mislead parliamentarians. There is a particular responsibility for community leaders and those in positions of trust in our community who have the resources to check information to ensure it is dependable. Regrettably, this is not always the case.

We will be interested to see the detailed submissions made to the consultation by a number of individuals and organisations where their initial comments reveal major flaws in data and errors in reasoning. We intend to undertake a detailed analysis to provide to MPs and to include on our website in coming months. This will include an analysis of the material in the Australian Christian Lobby material which includes inaccuracies, misleading claims, out of date and flawed data, assertions unsupported by any evidence and errors in reasoning including claims that overseas legislation has caused certain effects when there is no evidence to support this.

Another analysis will focus on the ineffective and flawed attempts to discredit major reputable, comprehensive reviews that have been released in the last few years and which have consistently supported voluntary assisted dying law reform. The same strategy, involving the same basic approach and the same or very similar quotes and references, is demonstrated in a number of commentaries. For example, the featured video on the Real Dignity Tasmania website uses the same approach and material as the latest booklet from the international

⁵ There seems to us to be an insidious undermining of trust in doctors as part of the campaign against voluntary assisted dying law reform. It is mostly implicit but sometimes it is made explicit, for example, the views expressed by Paul Russell of the SA based HOPE organisation who is also Deputy Chair of the Euthanasia Prevention Coalition. See for example, his insinuation that doctors are potential serial killers in <http://www.australianageingagenda.com.au/2011/05/31/article/Opinion-No-place-for-euthanasia/HEDGJQUKHK.html> and his criticism of a 2011 SA Bill which he claimed “abandons in my opinion the aged, the vulnerable, the disabled and the voiceless to the **whims of a doctor who may well be bent on seeing them die**”(our emphasis) (7.30 report transcript <http://www.abc.net.au/news/video/2011/04/01/3180405.htm>)

⁶ For example, frequent use of the term ‘killing’ as in a recent Australian Christian Lobby pamphlet promoting ‘care not killing’ and a letter to the Mercury on Saturday 9 March in which the letter writer condemned the “emotional manipulation” in the debate on “euthanasia” and then claimed that organisations like Beyond Blue were being undermined by “activists who would rather kill vulnerable people”. The recent ACL pamphlet uses the definition of ‘euthanasia’ from the Euthanasia Prevention Coalition, which is so broad it includes ‘double effect’ pain relief, voluntary withdrawal from treatment, terminal sedation and refusal of food and fluids, none of which are considered as ‘euthanasia’ under the legislation in the Netherlands or elsewhere. Anyone using that definition is able to vastly inflate the figures on the incidence of ‘euthanasia’ in the Netherlands and other countries and to provide a much distorted picture of the likely impact of proposed voluntary assisted dying legislation in Tasmania.

group with which Real Dignity Tasmania is associated, Alex Schadenberg's Euthanasia Prevention Coalition.

Despite the fact that the Real Dignity Tasmania group acknowledges in the video the importance of meeting the standards required by parliamentarians considering legislative reform, the video fails to a considerable extent to meet those standards. For example, the comprehensive and well argued academic report from the prestigious scientific organisation, the Royal Society of Canada, is dismissed on the basis of the opinion of one fellow anti-euthanasia activist, Margaret Somerville, and no mention is made of the fact that her claim was refuted in Canada at the time it was made.

In fact the blank pages of the book in the video are a very good representation of the absence of quality data and cogent, well-reasoned arguments so far advanced by groups like Real Dignity Tasmania against the proposal for voluntary assisted dying. We trust the group and others opposed to your proposal provides a more substantial submission to the consultation and that it is in keeping with the standards required by parliamentarians considering legislative reform.

CONCLUSION

The evidence that in Tasmania people are dying with prolonged suffering that cannot be relieved adequately is now extensive and we expect that more evidence will be provided as part of the consultation and in coming months. Such suffering is terrible for the individuals themselves and for everyone close to them and the effects can last years. There is also evidence that assisted dying is occurring but without the safeguards and scrutiny that legislation provides.

Your consultation paper will contribute to an informed and rational debate and on this occasion, there is no excuse for ill-informed speculation that ignores reputable evidence to the contrary from years of experience with assisted dying legislation overseas. As your paper shows, the evidence is also now well and truly in that voluntary assisted dying legislation is safe, including for the 'vulnerable' in our community, in fact, safer and more responsible than allowing the current situation to continue. Too much of the argument against voluntary assisted dying law reform generally, and against your specific proposal, is based on out of date, poor quality and incomplete 'cherry-picking' and piecemeal information that cannot be relied on for a responsible debate on our law.

We commend you on your soundly based and well-argued proposal and trust that the proposed legislation can be drafted as a matter of urgency and debated in the Parliament as soon as possible.