
Bioethics Outlook

Plunkett Centre for Ethics

A centre of Australian Catholic University and its healthcare partners

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An Australian Perspective on the UK's *Terminally Ill Adults* (*End of Life*) Bill

1. Introduction

1.1 We, Xavier Symons and Bernadette Tobin, work at the Plunkett Centre for Ethics, a centre of Australian Catholic University located on the campus of St Vincent's Public Hospital in Sydney.

1.2 Our experience includes (a) commenting on proposed legislation in all Australian jurisdictions about what in this country is called 'voluntary assisted dying' (but should be called 'physician-assisted suicide/euthanasia') and (b) working with individuals and institutions whose view is that the procedures legalized by such legislation (i) do not belong to medical practice properly understood, (ii) are unnecessary when good end of life treatment is available and provided, and (iii) has a deleterious effect on the treatment and care of elderly, frail, sick and/or demoralized individuals.

1.3 We make this submission having conversed with Dr David Albert Jones of the Anscombe Centre in Oxford about the relevance of Australian experience to your deliberations.

In this issue

We publish a submission made by Xavier Symons and Bernadette Tobin to the UK's Enquiry into its proposed *Terminally Ill Adults (End of Life) Bill*. Other submissions can be found on the website <https://bills.parliament.uk/bills/3774/publications>

We also publish a reflection on the debate in the UK by Julian Hughes, a retired consultant in old age psychiatry who was formerly the deputy chair of the Nuffield Council on Bioethics. Julian is an honorary professor at the University of Bristol. With Baroness Ilora Finlay he co-wrote *The Reality of Dying: Understanding the Issues*.

1.4 Summary: In this submission we

- set out key differences between VAD in Australia and PAS in Oregon;
- show how the safeguards in Australian laws have been rapidly eroded;
- recommend the rejection of any amendments to your Bill that would weaken the requirement for self-administration or would extend the timeframe of six months;
- recommend the strengthening of provisions for conscience protections by reference to legislation in the United States (and not Australia); and
- recommend the committee pick up two safeguards found in some Australian legislation (but not in US legislation).

2. VAD in Australia is not like PAS in Oregon

2.1 Voluntary assisted dying (VAD) legislation and practice in Australia is very different from physician-assisted suicide (PAS) in Oregon and other jurisdictions in the United States.

2.2 Notably, of the seven Australian jurisdictions that have legalised VAD (Victoria 2017; Western Australia 2019; Tasmania 2021; South Australia 2021; Queensland 2021; NSW 2022, Australia Capital Territory (ACT) 2024), none restrict it to self-administration or to patients who are expected to die within six months, whereas these are requirements in Oregon and in all ten US jurisdictions with PAS laws. In these respects, the Terminally Ill Adults End of Life Bill follows the Oregon model (S. 2(b), S. 18).

2.3 All Australian states allow practitioner administration (euthanasia) in some circumstances. This was allowed as an exception in Victoria ([VAD Act 2017](#), S. 46(c)(i)), and South Australia ([VAD Act 2021](#) (S. 64(c)(i)) only for people physically unable to self-administer, but other Australian states allowed practitioners to offer euthanasia wherever they deemed it appropriate and the Australian Capital Territory (ACT) simply allowed patients to choose between self-administration (assisted suicide) or practitioner administration (euthanasia) ([VAD Act 2024](#) (S. 82(3)(c)).

2.4 Similarly, the law in Victoria made an exception to the six-month expectation of death and allowed 12 months in the case of neurodegenerative diseases ([VAD Act 2017](#) (S. 9(4)), but Queensland later increased this to 12 months for all diseases ([VAD Act 2021](#) (S. 10(1)(a)(ii)), and ACT has abandoned the requirement of a specific timeframe if a person is 'approaching the end of their life' ([Act 2024](#) (S. 11(6)). The ACT legislation is very similar to the law in Canada in 2016, which only required that death be 'reasonably foreseeable' ([Criminal Code](#) 241.2(2)(d)).

3. Safeguards rapidly eroded

3.1 In these ways, and in many other ways, what were exceptions in the law in Victoria have gradually been expanded to become norms in other Australian jurisdictions, and requirements have been eroded. Where the law in Victoria is relatively close to the law in Oregon (and other US jurisdictions) the other Australian states have moved further from this model and the ACT law is closer to that in Canada (as it was in 2016) than to that in Oregon in 1997.

3.2 It should be no surprise that the numbers of assisted deaths in the first year in Australia jurisdictions have been much higher than in US jurisdictions. For example, in the [first year in Oregon](#) (p. 3) deaths by PAS were just 0.06% of all deaths, whereas the equivalent figure in [Western Australia](#) (p. 5) was 1.1% (rising to 1.6% in the [third year](#) (p. 6)), 1.2% in [Tasmania](#) (p. 4) and 1.6% in [Queensland](#) (p.1). These figures are all higher than the initial rate of medically assisted death in Canada. Note that 1.6% of the 581,363 [deaths in England and Wales for 2023](#) would be 9,301 deaths, whereas 0.06% would be 349 deaths.

3.3 Similarly, the protection of institutional conscience, which exists in all US states with PAS exists in no Australian states. Nevertheless, at least in Victoria non-participating institutions were not penalised. In contrast most Australian states that later legalised VAD (South Australia, Queensland, NSW) have introduced requirements on institutions to participate in various ways, and [ACT has criminalised operators](#) of institutions that fail to promote VAD (with strict liability). In this respect ACT has gone further than Canada.

3.4 These incremental changes from the law in Victoria, to the laws in the other Australian states, to the law in ACT, have been advocated by campaign organisations (such as Go Gentle Australia), and by politicians and academics, as ‘balancing access and safety’. However, the effect has been to subordinate safety to access.

3.5 The individuals and organisations that advocated for the sequential loosening of requirements in jurisdictions in Australia that have legalised VAD are now advocating for amendments to the laws in Victoria and Western Australia (and also in New Zealand) that would remove or further weaken safeguards in those jurisdictions.

3.6 The Committee should bear the above in mind when assessing submissions that cite the Australian experience, especially if these propose weakening the existing provisions in the Bill in the name of ‘balancing access and safety’. In an Australian context this argument has been the rationale for moving further away from the Oregon model of PAS and approaching or even surpassing the model of medical assistance in dying in Canada.

4. Provisions of the Bill on timeframes and self-administration

4.1 In the light of the Australian experience, we strongly recommend that the Committee do not accept any amendments that would weaken the requirement for self-administration or extend the limit of six months.

4.2 In the light of the Australian experience section 18 does not seem adequate to prevent expansion of ‘assisted dying’ to include practitioner administration (euthanasia). In particular, the phrase ‘assist that person to... self-administer’ (S. 18(6)(c)) is ambiguous. For example, if someone begins to self-administer by operating a medical device to inject the approved substance, but is unable to complete the action, would a doctor completing this action be assisting the ‘self administration’?

4.3. Similarly, the stipulation that ‘the final act of doing so must be taken by the person’ (S. 18(7)) might be held to include assistance by a doctor completing the ‘final act’ which was initiated by the person.

4.4 The stipulation that the coordinating doctor is not authorised ‘to administer an approved substance to another person’ (S. 18(8)) is weakened by the qualification ‘with the intention of causing that person’s death’. If the doctor knowingly administers the approved substance to the person, then it is redundant to add ‘with the intentional of causing the person’s death’. Moreover, it may be misleading, as a doctor might argue that they administered the approved substance not with the intention of causing the person’s death but with the intention of completing the act of self-administration by the person.

4.5 What is also lacking in the Bill is an overt statement of the legal consequence of practitioner-administration (euthanasia). Section 24(1) states that ‘a person is not guilty of an offence by virtue of providing assistance to a person in accordance with this Act’, and Section 24(3) states that it is a defence for a person charged with an offence under section 2 of the Suicide Act 1961 that they ‘reasonably believed they were acting in accordance with the Terminally Ill Adults (End of Life) Act 2024’ if they have ‘exercised all due diligence’. However, the Bill is silent on whether the same considerations apply to the offence of homicide (murder or manslaughter), which is treated differently in law and in prosecution guidance from assisting suicide, and is a more serious offence that is more likely to be prosecuted.

4.6 Section 18(6)(c) should therefore be deleted, and Section 18(8) should be replaced with:
Nothing in this Act

(a) authorises a person to administer an approved substance to another person;

(b) provides a person who knowingly administers an approved substance to another person with a defence against prosecution for homicide, or,

(c) alters the prosecution guidance on whether ‘acting in their capacity as a medical doctor, nurse, or other healthcare professional’ to a person in their care is a reason in favour of prosecution for homicide.

5. Conscience clauses

5.1 No section of the Bill refers explicitly to ‘conscience’ or ‘conscientious objection’, though Sections 4 and 23 bear on the issue of conscientious objection.

5.2 As with Australian legislation, there is no overt protection in the Bill for private, charitable or voluntary aided health or social care providers such as hospices and nursing homes. The Australian experience is that without overt protection, the conscience rights of such institutions have been eroded further in successive laws, culminating in ACT which criminalises operators of institutions that fail to promote VAD. There has also been a sequential erosion of protection of individual conscience in Australian jurisdictions.

5.2 In this context we would strongly recommend that the Committee do not look to Australia but look to legislation in the United States to inform improvements to the conscience provisions of the Bill.

6. Other provisions in the Bill

6.1 While, in general, VAD legislation in Australia has fewer safeguards than similar legislation in the United States, two safeguards occur in Australian law but not in the United States, both of which are worthy of consideration.

6.2. The [VAD Act of South Australia](#) overtly states that VAD is not palliative care for the purpose of law or regulation (VAD Act 201 S.5). This provision prevents palliative care professionals from being expected to provide VAD and protects funding of palliative care from being diverted into VAD.

6.3 Under Section 1 of the Bill add

(3) For the purposes of the law, regulation and state funding, the provision of assistance in accordance with Act will be taken not to constitute palliative care of the person.

(4) To avoid doubt, nothing in subsection (3) prevents a person or institution that is providing palliative care to a person from also providing assistance in accordance with this Act.

6.4 Lastly, both the legislation in Victoria ([VAD Act 2017](#), S. 8) and that in South Australia (VAD 2021, S. 12) prohibit healthcare professionals from initiating conversations about VAD. This provision has been controversial in Australia, but it has been controversial precisely because it has impeded the move towards the Canadian model of practice. In Canada VAD is actively promoted by governmental structures and health service providers and doctors are under an obligation to raise the subject with patients.

6.5 Replace 4(1) and 4(2) with

(1) A registered medical practitioner must not raise the subject of the provision of assistance in accordance with this Act with a person in the context of a medical consultation, unless the person has previously raised this issue with them or with another medical practitioner.

(2) Nothing in subsection (1) prevents a registered medical practitioner responding to requests for information about the provision of assistance in accordance with this Act.

We trust that these remarks and suggestions will be helpful to members of the committee. We would, of course, be very happy to provide any additional assistance to the committee which may be helpful.

Yours faithfully,

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What would Orwell say?

Julian C. Hughes

I know I'm not the first to notice the Orwellian connotations that swirl around the *Terminally Ill Adults (End of Life) Bill*. But it seems right to set them out, if only in order to allow them to be debated. Although, if they are to be debated, the debate should not be about whether the Orwellian implications exist – they do! – but about whether they matter. However, I think they do matter, for as soon as they are set out we can see them clearly and not through some sort of political haze. As Orwell wrote in his essay 'Politics and the English Language': 'when you make a stupid remark its stupidity will be obvious, even to yourself'. He continued, pertinently I think, 'political language ... is designed to make lies sound truthful and murder respectable, and to give an appearance of solidity to pure wind'.

I would point to three Orwellian inventions that we can use to analyze the language of "assisted dying". The first comes in *Animal Farm* in the form of the seven commandments, such as 'All animals are equal', which famously changed to 'All animals are equal, but some animals are more equal than others'. The second is Newspeak in *Nineteen Eighty-Four*. 'Don't you see,' Syme asks Winston, 'that the whole aim of Newspeak is to narrow the range of thought?' And third, also from *Nineteen Eighty-Four*, is Doublethink, 'the power of holding two contradictory beliefs in one's mind simultaneously, and accepting both of them'.

So let's get started. In 2006, after just over 70 years, the Voluntary Euthanasia Society changed its name to Dignity in Dying. This might have been inspired by Orwell's rule: 'Never use a long word where a short one would do'. It does, however, show how language can corrupt thought, something at which Orwell also railed. After all, although they are long words, the name "Voluntary Euthanasia Society" does tell you what the society is about. Whereas, "Dignity in Dying" does not. As things stand, "Dignity in Dying" is the aim of any hospice worth its salt. Worse than this, the Voluntary Euthanasia Society have in one move appropriated (sorry George!) the notion of "dignity", which is now associated with euthanasia and assisted suicide. Loss of dignity, the slogan suggests, is what you get if we don't have a law that sanctions doctors to assist patients to kill themselves or to be killed. Without this dignity-enhancing law, you will only have "suffering", a word that is now cunningly associated with the current state of affairs, which those who oppose the Bill wish to keep. Different types of "dignity" are out of the window. So, too, we need not debate the complexities around the idea that we must have

“choice”. And along with the idea of “dignity” will inevitably go the idea of “compassion”. Language, as Orwell suggested, corrupts thought. The concepts we are considering here are beautifully deep and layered. They are complicated. But in Newspeak, the aim is to simplify our thoughts through language.

Let’s move on to more current issues. Remember the seven commandments in *Animal Farm*. Well, for as long as I can recall, part of the World Health Organization’s definition of palliative care included the idea that it ‘Affirms life and regards dying as a normal process so that death should neither be hastened nor postponed’. But in the world of “assisted dying”, which now includes Australia, we find a palliative care physician, Dr Mewett of Victoria, saying to the Public Bill Committee on the 29th January 2025 that “assisted dying” ‘is part of palliative care’. On the same day, Professor Esmail, a retired professor but practising GP from Manchester, said he thought “assisted dying” would ‘enhance palliative care’. Thus, the commandment that palliative care should not hasten death has been changed to palliative care should not hasten death except sometimes; presumably because sometimes, in the spirit of not hastening death, hastening death enhances the aim of not hastening death. As the animals in *Animal Farm* discovered, progress can make life more difficult to understand.

None of this should be a surprise because even “assisted dying” is a euphemism, which is defined as ‘a mild or indirect word or expression substituted for one considered to be too harsh or blunt when referring to something unpleasant or embarrassing’. Euthanasia and assisted suicide are both unpleasant and embarrassing ideas. This is especially true when we think of the different types of euthanasia (it can be voluntary, but also non-voluntary and involuntary). Anyone who is inclined to point out that “suicide” means self-killing – and that this is what is being proposed in the current Bill for England and Wales, but also for Scotland, the Isle of Man and Jersey – is simply being mean: it’s an unpleasant and embarrassing idea. “Assisted dying” sounds so much nicer. It’s what they do in hospices. But, of course, what they do in hospices could be “enhanced” by encouraging self-killing. The commandments implicit in the Hippocratic Oath, in the moral fabric of our culture, in the foundations of the National Health Service, and even in the Mental Capacity Act (‘nothing in this Act is to be taken to affect the law relating to murder or manslaughter or the operation of section 2 of the Suicide Act 1961’) can all be changed in the blink of an eye. ‘No animal shall kill any other animal’, unless of course there is a good reason.

The debate is rife with these possibilities. There will be no expansion of the eligibility criteria for assisted suicide. Except that, as is the case almost everywhere, including in the venerable state of Oregon, the eligibility criteria have expanded. Non-terminal conditions can become terminal. Palliative care will improve if we have assisted suicide. Except that studies have shown how the rankings, in terms of palliative care, of jurisdictions with “assisted dying” mostly worsen.

What about Doublethink? Here's a nice one. On the 30th January, Alex Greenwich, a Member of the New South Wales Legislative Assembly, who introduced their voluntary assisted dying laws, told Kim Leadbeater's Committee that 'Voluntary assisted dying in New South Wales is an important form of suicide prevention'. Hence, we can state that assisted suicide is a form of suicide prevention. Importantly for Doublethink, we must believe *at the same time* that in one act we can both promote and prevent self-killing. Danny Kruger MP (on the basis of research) made this point to Alex Greenwich: 'The fact is that unassisted suicide rises in states that have assisted suicide laws, because suicide is contagious'. But the reply was pure and simple Doublethink: 'voluntary assisted dying is a form of suicide prevention'.

Let's end with more Newspeak. Many of us who are against the proposed legislation have pointed to the concern that in several jurisdictions people give feeling a burden as a reason for wanting to end their lives. No one should feel a burden. Nevertheless, Professor Blake, a law professor from the University of Western Australia, suggested to the Committee on 30th January that 'People can feel that they are a burden, and that is part of their autonomous thinking.' For Professor Blake, as long as the decision is valid and informed, that the person makes it voluntarily and with capacity, the fact that the person feels a burden is simply part of the decision-making context. Two days before, Dr Jessica Kaan, medical director for End of Life Washington, had said to the Committee that feeling you are a burden could be 'a valid reason among many' for wishing to have assisted suicide.

Feeling a burden, rather than being something to be worried about, becomes simply a part of the furniture. As in Newspeak, the range of thought has been narrowed. It's no longer necessary to feel shocked by fifty per cent of people feeling they must end their lives because they sense they are a burden. This is merely a fact of life, neither good nor bad, neither shocking nor a failure of social care. The language of being a burden has successfully been simplified.

Who knows what Orwell would think about assisted suicide and euthanasia? But we can be fairly sure that he would have things to say about the dangers of the language of the debate. Language can corrupt thought. We need to see clearly how language is being used for political purposes. The worry is that this sort of political use of language does not enhance thought, but causes us to think strangely and, in so doing, coarsens our lives.

Julian C. Hughes is a retired consultant in old age psychiatry, professor of old age psychiatry and of the philosophy of ageing. He was previously deputy chair of the Nuffield Council on Bioethics. He remains an honorary professor at the University of Bristol. He has recently coedited (with Baroness Ilora Finlay) 'The Reality of Assisted Dying: Understanding the Issues'.