Submission into the Voluntary Assisted Dying Bill 2021

Submission No.:	81
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Publication:	Making the submission and your name public
Position:	I/We do not support the Voluntary Assisted Dying Bill
Comments in relation to:	Eligibility criteria* ,The request and assessment process,Administration of the substance,Safeguards,Conscientious objection by either individuals or entities
Attachments:	See attachment
Submitter Comments:	

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Submission to Qld Parliamentary Inquiry into what has been termed Voluntary Assisted Dying Bill 2021.

Part 5 para 82 page56 Eligibility Requirements for health practitioners

It seems the minimum requirements for a medical practitioner are general registration for 5 years.
Such practitioners would have minimal experience of terminal care, minimal experience of a disease process, minimal experience of patients who are terminally ill.
Such practitioners would not be able to properly discern symptomatology that could be related to mental state or to progressive disease. For example, a 92 year old patient of mine recently died. She had lived at home for 8 months with a R pelvic cancer mass, pulmonary metastases. Her requirements for pain control were nil even though she had Oxycodone tablets in her bedside drawer. She was not in pain. She eventually entered a local nursing home for the final 3 weeks of her life where she died peacefully, surrounded by family under Palliative Care. She enjoyed her family attention for the last 8 months of her life.
Under the Qld Labor VAD law, fearful of an “awful death” she could easily have been exposed to premature death by Euthanasia or Assisted Suicide overseen and wrongfully diagnosed as being “terminal” by inexperienced practitioners or nurses. A potential wrongfully premature death.

15 years ago my stepmother had an apical lung cancer surgically

removed. A short while later she developed a lump in her neck. Her

Brisbane chest specialist had a PET scan done and she was told the cancer had returned and she was given a prognosis of 3-6 months. I did not agree with the prognosis or the diagnosis, her GP felt the same and the lump turned out to be an abscess and she had a Staph infection treated with antibiotics and lived another 10 years. Under the Qld Labor VAD law, and with an inexperienced practitioner, she could easily have been Euthanased, fearful of an "awful death". Another potential wrongful death under Labor's proposed law.

Para 83 page 58 Eligibility to act as administering practitioner

A nurse practitioner who meets the approved requirements.
What are the requirements?

There is a terrible conflict between the duty of a nurse to care for and heal, and the requirement of what is essentially the killing of the patient. How does the nurse in an isolated rural situation cope with the physical effects of dying, the possibility that the drug administered is not lethal, without the immediate support of a doctor physically available for advice?

PROPOSALS: A proposed bill like this should clearly make it law that at least one approving doctor is a specialist in the area of disease of the patient and must carry out at least a 60minute consultation with the patient. If the patient is showing signs of depression, a qualified psychiatrist must examine the patient.
There must be evidence that the patient has had consultation with and received information from a Palliative care specialist.

Nurse practitioners should not be encumbered with administering Euthanasia drugs to patients.

A doctor must be physically available and nearby the premises if Euthanasia drugs are administered.

Division 4 Section 8 page 13.

Voluntary Assisted Dying,(termed as PAS or Physician Assisted Suicide in other States,) not suicide.

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Comment: This statement is plainly misleading,and is clear George Orwell 1984 DOUBLETHINK (holding of two contradictory ideas simultaneously , in this case 1. Commit suicide by ingesting a lethal substance or freely permitting a person to inject a lethal substance into your iv line,2. You are not committing suicide.) , which undermines public confidence in any Government that produces such statements, and should be deleted.

Part 6 Division 1 Conscientious Objection page 59

(2) a,b

Comment: This insistence to provide information and details, clearly makes the health practitioner or Institution cooperate with Euthanasia. The health practitioner should be allowed to state to the patient that he/she does not believe Euthanasia is the solution and to suggest and or promote Palliative Care as a solution. And is not obliged to provide information on Euthanasia or where it is accessed. As a matter of interest for the Committee, Professor Cathy Eagar of Wollongong has found that pain is **not** in the top 5 reasons for requesting Euthanasia. In my own experience, I have found that analgesia works, on one occasion when I suffered a Stonefish sting, that required 10mg Oxycodone to be

pain free, and another after a large hip haematoma after falling off my paddleboard at Tallebudgera, requiring 5mg Oxycodone to be pain free.

Practitioners should not be forced to provide information or make referrals they know to be harmful, or could lead to a wrongful,

unnecessary premature death. Patients will know that a practitioner does not make such referrals and will consult with those who they know will do such things. Doctors and Institutions such as hospitals or Care homes have a duty to be conscientious, fundamental to medical ethics. Patient care cannot be proper without conscientious medical professionals, and many know that legalised VAD or euthanasia is extremely harmful for society, and can easily mislead a patient to a wrongful premature death. Many doctors do not want to see a community become habituated to death procured by doctors and nurses. Doctors are also well aware of wrong prognoses and diagnoses and the possibility of wrongful premature death because of a wrong prognosis.

Conscientious Objection rights also apply to hospitals and Care Homes. However I firmly believe that if Palliative Care is properly, therefore fully, available in all its forms by the requested funding,and personnel increase, Euthanasia will not be requested, except out of fear due to misinformation and exaggerated accounts in the media by some health practitioners of “awful deaths”.

People want to die at home- increase Home Based Aged Care and Home Based Palliative Care.

The thought of dying a possibly lonely hospital death is quite depressing and brings on thoughts of Euthanasia

Bring Palliative Care to people’s homes.

This is compassion at the end of life.

Part 2 paragraph 10 Eligibility page 14

1 (a) (disease, illness or medical condition) is expected to cause death within 12 months.

Comment: this is a grossly broad definition of eligibility, and with a prognosis of 12 months in which time anything is possible to bring about a revision of prognosis such as advances in treatment and even new treatments. Or spontaneous recovery responding to previous treatments. In a 12 month period there may well be a resolution of underlying depression changing the patient's outlook. Again during this extended period coercion may be brought to bear that was withheld previously, to obtain progress towards an earlier death. There is a huge potential for wrongful premature death inside a 12 month period.
All doctors know that prognoses, especially in cancerous diseases, can be quite inaccurate with earlier or much later deaths occurring, or even no death at all.
Make the stipulated prognosis to be 3 months.
Also under this section **Eligibility** there should be the instruction :
There must be evidence that the patient has had consultation with and received information from a Palliative care specialist.

Division 4 paragraph 7, page 12:
Health worker not to initiate discussion…

Subsection (2) However despite subsection (1)....

Comment: Essentially this subsection is somewhat contradictory and permits a healthworker to talk about Euthanasia or to initiate VAD discussion. This is extremely dangerous because it gives a healthworker opportunity to talk about Euthanasia VAD based on a healthworker's

own subjective opinion, and possibly own subjective experience of a particular death. Health Workers can easily imagine symptoms that are not subjective to a patient because the patient is unconscious, and then pass on inaccurate accounts of a death, describing deaths as "awful" , and become motivated to encourage VAD to patients by initiating discussion, as long as the requirements, in this case of **Subsection (2) (a)** and **(b)** are met.

Inequitable access to Palliative Care

Patients with a terminal diagnosis should be able to access Palliative Care immediately.

In 2018 Qld had 49 Full Time Equivalent Palliative specialists. The recommendation is 2 FTE Palliative specialists per 100,000 people. Qld would need 101 FTE Palliative specialists.

Palliative sedation is voluntarily available for those experiencing moderate or severe pain at the end of life. This **NOT** killing the patient.