SUBMISSION:

Queensland
Voluntary Assisted Dying Bill 2021

AUSTRALIAN CHRISTIAN LOBBY

About Australian Christian Lobby

Australian Christian Lobby's vision is to see Christian principles and ethics influencing the way we are governed, do business, and relate to each other as a community. ACL seeks to see a compassionate, just and moral society through having the public contributions of the Christian faith reflected in the political life of the nation.

With more than 160,000 supporters, ACL facilitates professional engagement and dialogue between the Christian constituency and government, allowing the voice of Christians to be heard in the public square. ACL is neither party-partisan nor denominationally aligned. ACL representatives bring a Christian perspective to policy makers in Federal, State and Territory Parliaments.

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Health and Environment Committee
Parliament House
George Street
Brisbane QLD 4000

hec@parliament.qld.gov.au

1 July 2021

Dear Sir/Madam

On behalf of the Australian Christian Lobby (ACL), thank you for the opportunity to make a submission with regard to the *Voluntary Assisted Dying Bill* (QLD).

Please find attached our submission on this important issue.

I am available to discuss any issues which may arise from this submission.

Yours sincerely,

WFrancis

Wendy Francis
Queensland and Northern Territory Director

INTRODUCTION

This submission addresses the fundamental flaws in the proposed *Voluntary Assisted Dying Bill 2021* (QLD) (the **Bill**). The Australian Christian Lobby (the **ACL**) is opposed to any laws that sanction the killing of the sick, the elderly and the vulnerable. This Bill is the most extreme of its kind in Australia and seeks to introduce access to state sanctioned suicide in a way that is far more concerning than similar laws introduced in other states. The flaws in this Bill are enough to render the Bill too dangerous to be passed and the ACL submits that the Bill should be rejected in its entirety.

The ACL is committed to the dignity and wellbeing of the elderly, the sick and the vulnerable. That is why we strongly support improvement of the quality and access to world-class palliative care.

EXECUTIVE SUMMARY

The Bill fails to provide adequate safeguards for the terminally ill and vulnerable, nor does it sufficiently protect people or entities that are conscientiously opposed to state-assisted suicide.

Below are the key failings of the Bill:

1. The Bill undermines the importance of palliative care. A person should not be able to access voluntary assisted dying (**VAD**) unless they have first exercised their right to palliative care;
2. The Bill doesn't protect health care workers. A religious health care worker who has a conscientious objection to VAD should not have to participate in any part of the VAD process, including referrals;
3. The Bill fails to protect health care workers from regulatory punishment. A conscientious objector's choice not to participate in VAD should be irrelevant to any consideration about the person's conduct or performance under other health legislation;
4. The Bill doesn't protect faith-based hospitals and organisations. The Bill requires faith-based organisations to act contrary to their conscientious position and their faith-based objects. Faith-based organisations should be able to refuse to participate in every aspect of the VAD process, including providing access to information about VAD;
5. The Bill fails to protect faith-based organisations from regulatory punishment. The mere fact that a faith-based hospital or facility does not participate in the VAD process should not be the subject of a health service complaint;
6. The Bill does not protect the mentally unwell and vulnerable. No-one should be able to access VAD without first having a mental health assessment by a psychologist to exclude any undiagnosed mental illness or distress;
7. A health care worker can initiate a conversation about VAD. A health care worker should never be able to discuss VAD except at the request of a patient;
8. The Bill does not require expert and quality medical care for the vulnerable. At the very least a coordinating practitioner should have 10 years' clinical experience and an existing doctor/patient relationship with the patient. Any consulting practitioner should have at least 10 years' clinical experience in the disease, illness or medical condition suffered by the patient;
9. The Bill lacks an essential cooling off period before someone is able to commit suicide. There needs to be a mandatory cooling off period of at least 14 days before a person may follow through with taking the VAD substance;

10. The Bill tries to cover up that someone has committed suicide. If someone takes a VAD substance to die, their death certificate should record that fact.

SPECIFIC SUBMISSIONS

We set out below our submissions on the failures of the Bill. We identify safeguards and protections that are missing which should in no way be taken to be an approval of the Bill even if all missing safeguards and protections are addressed. The Bill is still fundamentally flawed and should be rejected.

Clause 7 – Health care worker not to initiate discussions about voluntary assisted dying

Subclause 7(2) allows a health care worker to initiate a discussion about, or suggest, voluntary assisted dying if the worker also informs the person about treatment options or palliative care available to the person. This subclause should be removed, ensuring that the heading to the clause is accurate. The only circumstance in which a health care worker should be legally allowed to discuss voluntary assisted dying with a person is at the person's request.

Instead, when providing a health service or personal care service, a health care worker should focus on providing the best level of service to the person, identifying and treating the person's symptoms and respecting the inherent dignity of the person. This would accord with the principles stated in the Bill, particularly those set out in paragraphs 5(a) and (b).

Clause 8 – Voluntary assisted dying not suicide

This clause should be removed. Stating that a person who dies after self-administering, or being administered, a voluntary assisted dying substance in fact dies from the disease, illness or medical condition from which the person suffered is inaccurate and dishonest. If a person dies as a result of the provision of assisted dying, the laws should acknowledge the truth of what it has allowed to take place.

Clause 8 directly conflicts with other provisions of the Bill:

1. a coordinating practitioner must inform a person (who has requested voluntary assisted dying) that the expected outcome of self-administering or being administered a voluntary assisted dying substance is death (cf clause 22);
2. a coordinating practitioner and an authorised supplier must inform a person of the period within which the person is likely to die after self-administering a voluntary assisted dying substance (cf subclauses 65(1) and (2) and 70(2));

In none of these cases is the person told that, after self-administering or being administered a voluntary assisted dying substance, they will die of the disease, illness or medical condition from which they suffer.

Clause 10 – Eligibility

The eligibility criteria should be amended so that a person is ineligible for access to voluntary assisted dying if the person has not first been informed and tried palliative care, or other medical treatments intended to relieve pain and distress.

If a person receives care focussed on symptom relief, the prevention of suffering and an improvement of quality of life, they may no longer have any desire to seek access to voluntary assisted dying. The ACL notes that the AMA's position that doctors have a responsibility to initiate and provide good quality end of life care.

The eligibility criteria should be further amended so that a person is ineligible for access to voluntary assisted dying unless the person has, within the month before a first request is made, had a mental health assessment by a psychologist, ensuring that the person is not suffering from any undiagnosed mental illness or distress affecting their ability to request voluntary assisted dying.

Virtually all people facing death or battling an irreversible, debilitating disease suffer depression at some point. Overseas experience shows that requests for assisted dying are revoked if a person's depression and pain are satisfactorily treated.

Clause 11 – Decision-making capacity

Subclause 11(2) states that a person is presumed to have decision-making capacity in relation to voluntary assisted dying unless there is evidence to the contrary. This subclause should be removed. Given the gravity of the decision, nothing should be presumed about the person or their circumstances.

This clause should also be amended to specifically state that a person with a disability or mental illness is taken to lack decision-making capacity (see our comments on clause 13 below).

Clause 12 – Residency exemptions

One of the criteria for eligibility for access to voluntary assisted dying is that the person is ordinarily resident in Queensland or has been granted an Australian residency exemption by the chief executive under clause 12. Subclause 12(2) *requires* the chief executive to grant an exemption if the person has a substantial connection to Queensland and there are compassionate grounds for granting the exemption.

This clause should be removed. Its application is unclear. What is a substantial connection to Queensland? Is the fact that a person, at some time in their life, owned property in Queensland and regularly holidayed there enough to establish a substantial connection? Such vagueness is inappropriate for an exemption in respect of which the chief executive has no discretion and must grant.

Clause 13 – Disability or mental illness

This clause is clumsily drafted. It should be removed and clause 11 should be amended to specifically state that a person with a disability or mental illness is taken to lack decision-making capacity.

Clause 14 – Person may make first request to medical practitioner

A person may make a request for access to voluntary assisted dying verbally, by gestures or by other means of communication available to the person (subclause 14(3)).

The ability to make a request by gestures leaves too much scope for misinterpretation and should be removed. Suppose a person points two fingers to their head to indicate shooting themselves in the head. While this may be interpreted as a clear and unambiguous sign that the person is requesting access to voluntary dying, it may in fact be expressing frustration with family members or with the level of care being provided to the person.

If the person is unable to make a request verbally or by some other means of communication (eg using Auslan), how can it be established that a person truly has decision-making capacity?

Any reference to allowing a person to communicate by gestures should be removed from the Bill [cl 42, 50 and 51 also refer].

Clause 19 – First assessment

The coordinating practitioner for a person must assess whether or not the person is eligible for access to voluntary assisted dying. It is noted that some eligibility criteria, such as evidence of decision-making capacity, may require legal or legal-medico expertise rather than medical expertise.

But more concerningly, this assessment could be made by a practitioner without an existing doctor/patient relationship with the person, or a practitioner lacking any significant medical expertise or clinical experience. The coordinating practitioner may be a practitioner holding general registration with 5 years' experience and need not be a practitioner that specialises in the person's underlying disease, illness or medical condition. Even if a specialist, the practitioner need only have a years' experience as a specialist. This is unacceptable. Clause 82 should be amended to require appropriate levels of experience, as recommended below.

The expertise of another, by a referral under clause 21, is not sought unless the coordinating practitioner is unable to assess whether the person is eligible for access to voluntary assisted dying.

Clause 21 – Referral for determination

If the coordinating practitioner for a person is unable to assess whether or not the person has a disease, illness or medical condition that meets the eligibility criterion set out in paragraph 10(1)(a), has decision-making capacity, or is acting voluntarily and without coercion (the **referral matters**), the coordinating practitioner must refer the person to a registered health practitioner or another person (the **referee**) who has the appropriate skills and training to determine the matter. However, the coordinating practitioner is *not* required to adopt the referee's assessment of the matter, even though the coordinating practitioner was unable to assess the matter him or herself.

Clause 21 should be amended to:

1. enable the coordinating practitioner to refer each referral matter to a referee once (to avoid any ability for opinion shopping), allowing a maximum of 3 referrals per person;
2. require the process to end if the coordinating practitioner does not adopt the referee's assessment of any matter referred.

Clause 32 – Referral for determination

If the coordinating practitioner assesses the person as meeting the requirements of the first assessment, the practitioner must refer the person to another medical practitioner for a consulting assessment (clause 25). The second medical practitioner (the **consulting practitioner**) must independently assess whether the person is eligible for access to voluntary assisted dying. The referral process described above applies in relation to the consulting practitioner. It suffers from the same flaws as clause 21.

Clause 32 should be amended so that the process ends if:

1. the same referral matter is referred to a referee under both the first assessment and the consulting assessment (there is clearly an issue if a matter relating to eligibility requires the opinion of 4 persons and over which opinion could be equally divided 2:2); or
2. the coordinating practitioner does not adopt the referee's assessment of any matter referred.

Clause 36 – Referral for further consulting assessment if person assessed as ineligible

If the consulting practitioner assesses the person as ineligible, the coordinating practitioner may refer the person to another medical practitioner for a further consulting assessment. The Bill does not limit the number of times a further consulting assessment can occur.

Clause 36 should be removed. If the consulting practitioner assesses the person as ineligible, the Bill should state that the process ends.

Allowing for further consulting assessments enables the perverse result that a person may be eligible for access to assisted dying even if more medical practitioners do not consider the person to have met at least one eligibility criterion than those that do. Consider, for example:

1. a person is assessed as meeting the requirements of the first assessment (despite the coordinating practitioner not adopting a referee's determination of a matter);
2. a person is assessed as being ineligible by a consulting practitioner (whether or not any matters were referred to a referee for determination);
3. a further consulting practitioner assesses the person as ineligible (whether or not any matters were referred to a referee for determination);
4. a further consulting practitioner assesses the person as eligible.

In these circumstances, 5 practitioners considered a person's eligibility, or at least one aspect of a person's eligibility, for access to voluntary assisted dying. Three practitioners did not consider that at least one eligibility criterion was satisfied, but the person will be eligible for voluntary assisted dying based on the assessment of 2 practitioners; their opinion effectively outweighing the contrary opinion of 3 practitioners. This is nonsensical.

Clause 37 – Person assessed as eligible may make second request

If the person makes a second request with the assistance of an interpreter, the interpreter must certify on the request that the interpreter provided a true and correct translation of any material translated. The Bill should be amended to provide for a penalty if the interpreter does not do so. If the Bill does not require or provides no sanctions in relation to the integrity of persons involved in the process, a person making a decision with irreversible consequences is not adequately protected.

Clause 43 – When final request may be made

Subclause 43(2) allows the person to make a final request before the end of 9 days after the person's first request if the coordinating practitioner considers that the person is likely to die, or lose decision-making capacity, before the end of that period and that opinion is consistent with the consulting practitioner's assessment.

Subclause 43(2) should be removed from the Bill. If a person is likely to die or lose decision-making capacity before the end of 9 days after the person's first request, the person is not in need of assistance to die sooner.

Clause 46 – Final review by coordinating practitioner on receiving final request

The Bill provides that a person may, at any time, decide not to take any further steps in the process, even if after the request and assessment process has ended (clause 48). Subclause 46(4) should be amended to require the coordinating practitioner to inform the person of this fact at the time a copy of the final review form is given to the person. Further, there should be a criminal penalty if the coordinating practitioner fails to do so.

Part 4 – Division 1 – Administration of voluntary assisted dying substance

This Division should be amended to include a mandatory cooling-off period of 14 days before a person may self-administer, or have administered, a voluntary assisted dying substance. This is consistent with the law in Victoria and overseas (the law in Oregon, USA requires a 15 day cooling-off period, with limited exceptions, and Canadian legislation provides for a 10 day cooling-off period).

Clause 51 – Revocation of administration decision

If a person makes an administration decision, that is, decides to self-administer, or have administered, a voluntary assisted dying substance, and subsequently revokes the decision, subclause 51(4) provides that a person is not prevented from making an administration decision again.

However, the Bill should be amended to require a new request and assessment process at the end of 3 months after the person first makes an administration decision. Hesitation in carrying out an administrative decision indicates that despite the person making requests and going through the assessment process, the person is having second thoughts and not committed to their initial decision.

Clause 52 – Self-administration–authorisations

Subclauses 52(6) and (7) should be amended to clarify that the supply of the voluntary assisted dying substance to the person is for the person to self-administer the substance.

Clause 54 – Witness to administration of voluntary assisted dying substance

The Bill does not preclude the same person from both witnessing the administration of a voluntary assisted dying substance by an administering practitioner and certifying the signing of a person's second request as a witness (clause 39 refers). To ensure greater checks in the process, the Bill should be amended to require that the same person cannot carry out both roles.

Clause 61 – Role of contact person in case of self-administration decision

Subclauses 61(1) should be amended to clarify that the supply of the voluntary assisted dying substance by the contact person is for the person seeking voluntary assisted dying to self-administer the substance.

Clause 64 – Contact person may refuse to continue in role

Clause 64 should be amended to *require* a contact person to give a voluntary assisted dying substance to an authorised disposer if the contact person refuses to continue in the role but remains in possession of the substance. While such action is permitted under clause 61, it is not required. Such amendment is necessary to ensure that the substance is not used in another situation without lawful authority. The Bill should include a criminal penalty for a failure to do so.

Clause 69 – Authorised supplier to authenticate prescription

There is no penalty if an authorised supplier fails to authenticate a prescription as required by clause 69. The Bill should be amended to correct this oversight.

Clause 81 – Cause of death certificate

Consistently with our comments on clause 8, paragraph 81(3)(a) should be amended to require a cause of death certificate to state that a person has died after self-administering, or being administered, a voluntary assisted dying substance. The law must acknowledge the truth of what it has allowed to take place. The ACL has no objection to the underlying disease, illness or medical condition from which the person suffered also being mentioned on the death certificate, but not in lieu of the true cause of death being stated on the certificate.

Clause 82 – Eligibility to act as coordinating practitioner or consulting practitioner

As mentioned above (see our comments on clause 21), a person is able to act as coordinating practitioner or consulting practitioner without sufficient experience and without any expertise in the disease, illness or medical condition suffered by the person. This is unacceptable.

Clause 82 should be amended to require:

1. a coordinating practitioner to have at least 10 years' clinical experience; and
2. a coordinating practitioner to have an existing doctor/patient relationship with the person, unless the practitioner has a conscientious objection; and
3. a consulting practitioner to have at least 10 years' clinical experience in the disease, illness or medical condition suffered by the person.

Further, if an overseas-trained specialist, the practitioner should not be eligible to act as a coordinating or consulting practitioner if the practitioner only holds provisional registration.

Clause 84 – Registered health practitioner with conscientious objection

Subclause 84(2) should be removed. If a registered health practitioner has a conscientious objection, the practitioner should be able to refuse to participate in various steps in the voluntary assisted dying process and should not be required to assist a person further. A person who truly wants information or to make a request under the voluntary assisted dying process will not be deterred by a practitioner who exercises a conscientious objection. Rather, the person will seek out a practitioner that does not have such an objection.

Clause 85 – Speech pathologist with conscientious objection

For the reasons outlined above, speech pathologists with a conscientious objection should be treated in the same way as a registered health practitioner with a conscientious objection. On this basis, paragraphs 85(2)(b) and (c) and subclauses 85(3) and (4) should be removed.

Part 6 – Division 1 – Conscientious objection

This Division should be amended to provide a pharmacist (who would otherwise be an authorised supplier) and an interpreter with the same rights as a registered health practitioner and a speech pathologist to refuse to participate in various steps in the voluntary assisted dying process.

This Division should also be further amended to ensure that persons who exercise these rights do not face any discrimination for doing so, particularly in relation to the renewal of their registration or future employment decisions. Discriminatory actions should be subject to a criminal penalty.

Part 6 – Division 2 – Participation by entities

This Division should be amended to exclude entities that are faith-based hospitals, hospices or organisations providing residential aged care. Providing voluntary assisted dying, and enabling any step in the voluntary assisted dying process, is precluded by the ethos of such entities.

This Division should be amended so that such entities are not required to:

1. allow reasonable access to a consulting practitioner; or
2. take reasonable steps to facilitate the transfer of a person for the purposes of a consulting assessment or to allow an administration decision to be made (cf clauses 95 and 96).

However, if these amendments are not accepted and faith-based hospitals and facilities are to be subject to this law, this Division should be amended so that such entities:

1. are not compelled to act, actively or passively, to facilitate any step of the voluntary assisted dying process; but
2. may not prevent a patient or resident from leaving their premises to take such a step.

This will enable these entities to deliver care to patients in ways that accord with their mission and values but will not prevent a patient or resident from carrying out a step of the voluntary assisted dying process elsewhere.

It is noted that if a patient or resident in a faith-based hospital or facility should wish to access to voluntary assisted dying, the patient or resident is able to contact the official voluntary assisted dying care navigator service (clause 156).

Whichever approach is adopted, this Division should be specifically amended to ensure that it is illegal for a voluntary assisted dying substance to be on the premises of a faith-based hospital or facility, supported by a criminal penalty for any person who brings a voluntary assisted dying substance onto such premises.

Clause 117 – Functions

This clause should be amended to preclude the Voluntary Assisted Dying Review Board from referring any issue to an entity mentioned in paragraph 117(1)(c) that relates to the mere fact that a relevant person exercised their right to refuse to participate in any aspect of the voluntary assisted dying process.

This clause should be further amended to require the Board to publicly report, each quarter, on:

1. the number of persons who have made requests under the Act during the previous quarter; and
2. the number of persons who have died during the previous quarter as a result of self-administering, or being administered, a voluntary assisted dying substance.

This information should also be required to be available on the Board's website.

Clause 141 – Inducing a person to request, or revoke request for, voluntary assisted dying

This clause should be amended to specifically remove the reference to revoking a request. It should not be a criminal offence to encourage someone to live and there is no real risk of a person dishonestly inducing another person to revoke a request for voluntary assisted dying; indeed it is difficult to conceive of circumstances in which this could occur. It is certainly not a risk that warrants a maximum criminal penalty of 7 years.

Clause 152 – Compliance with this Act relevant to professional conduct or performance

This clause should be amended to specifically state that, for the purposes of subclause 152(1), the mere fact that a relevant person exercised their right to refuse to participate in any aspect of the voluntary assisted dying process under this Act is irrelevant to any consideration about the person's professional conduct or performance.

Clause 155 – Technical error not to invalidate process

This clause should be removed. Given the nature of the decisions being made under this legislation, nothing less than strict compliance with the law should be required.

Clause 158 – Authorised suppliers

This clause should be amended to specifically exclude a person who would otherwise fall within a class of registered health practitioners authorised to supply a voluntary assisted dying substance if the person has a conscientious objection and does not wish to participate in any step relating to preparation or supply of a voluntary assisted dying substance.

AMENDMENTS TO OTHER LEGISLATION

Health Ombudsman Act 2013

This Act should be amended to specifically state that:

1. the mere fact that a relevant person exercised their right to refuse to participate in any aspect of the voluntary assisted dying process under the proposed *Voluntary Assisted Dying Act* may not be the subject of a health service complaint; and
2. the mere fact that a faith-based hospital or facility does not participate in any aspect of the voluntary assisted dying process under the proposed *Voluntary Assisted Dying Act* may not be the subject of a health service complaint.

Health Practitioner Regulation National Law (Queensland)

This law should be amended to specifically state that the mere fact that a relevant person exercised their right to refuse to participate in any aspect of the voluntary assisted dying process under the proposed *Voluntary Assisted Dying Act* may not be the subject of a notification or referred matter under the national law.

GENERAL SUBMISSION

In addition to our specific submissions on the clauses of the Bill we make the following observations about why introducing any kind of voluntary assisted dying legislation is contrary to the life and dignity of all Queenslanders.

Queenslanders Deserve Quality Palliative Care

An ageing population requires greater availability of quality palliative care services. However, it is clear that current palliative care services are not adequate to meet the needs of the elderly and dying in Queensland.

The ACL acknowledges the extensive inquiry that the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the **Committee**) undertook prior to the tabling of this Bill. What became clear through this inquiry was how inadequate palliative care services in QLD currently are and how much needs to be done to make them satisfactory, let alone exemplary.

Queenslanders deserve the best end-of-life care. The ACL notes with concern that the Committee raised the following issues with current palliative care in Queensland:

1. Access to local palliative care is severely lacking, with little access for remote Queensland communities;
2. There are no palliative care hospices outside of South East Queensland;
3. Queensland lacks a consistent and coordinated approach to palliative care provision throughout the State, with individual Hospitals and Health services conducting their own piecemeal approach;
4. Palliative care in residential aged care facilities is not meeting the need in these facilities;
5. There is insufficient access to after hours palliative care in rural Queensland, which can be the source of significant distress to patients;
6. There is not enough funding, and even the available funding is inefficiently applied and even sometimes misappropriated to other sub-acute services; and
7. Palliative care in Queensland is suffering a large workforce shortage which will only worsen as the demand increases with an ageing population.[1]

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[1] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, "Aged care, end-of-life and palliative care: findings and recommendations (Report No. 33), *Paper No.4*, 56th Parliament, 31 March 2020, last accessed 16/06/2021.

Associate Professor Natasha Michael is an expert in palliative care and is concerned that a misunderstanding of palliative care has created an enthusiasm for physician assisted suicide. She writes:

> *"Palliative care is deeply misunderstood. It is viewed simply as the care of the dying, without understanding the totality of what it can offer, when it is doe well, Stories of bad deaths arise not simply from the memory of the repugnance of death, but from one of ill preparation and failure of professionals and society to help families delve deeply into what matters most."*[2]

The Government should be prioritising the critical improvement of palliative care in Queensland. This Bill undermines this priority. Palliative care is necessary to provide needed care to Queenslanders who are terminally ill. Making VAD an option creates a perverse disincentive for the Government to focus instead on the cheaper option of ending the lives of the terminally ill, rather than providing them with much needed comfort and care in their final days.

The Australian Medical Association's 2016 position statement on Euthanasia is very clear that the Australian medical community sees palliative care as a top priority in the provision of end-of-life care and that it should be prioritised above access to VAD.[3] The ACL agrees with the AMA's statement that as a matter of highest priority, governments should strive to improve end of life care for all.[4] The AMA has stated that the government should prioritise palliative care through:

1. *the adequate resourcing of palliative care services and advance care planning;*
2. *the development of clear and nationally consistent legislation protecting doctors in providing good end of life care; and*
3. *increased development of, and adequate resourcing of, enhanced palliative care services, supporting general practitioners, other specialists, nursing staff and carers in providing end of life care to patients across Australia*.[5]

Doctors have taken the Hippocratic Oath and should be providing healing medical care to their patients. Doctors should not be co-opted into assisting the vulnerable to commit suicide. The AMA has said that doctors should not be involved in medical interventions that have as their primary intention the ending of a person's life.[6]

Voluntary Assisted Dying is a Danger to the Most Vulnerable

Introducing any kind of state-assisted suicide legislation is an abrogation of our responsibility as a society to some of the most vulnerable members of our community.

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[2] Michael, Natasha, "We can't let voluntary assisted dying negate our commitment to the ill" (The Age, 23 May 2019) [redacted] last accessed 15/06/2021.

[3] Australian Medical Association, "Position Statement: Euthanasia and Physician Assisted Suicide" (2016) [redacted] last accessed 29/06/2021, [1.5].

[4] Ibid, [1.6].

[5] Ibid.

[6] Ibid, [3.1].

Paul Keating understood this when he wrote the following during the public debate about assisted suicide laws in Victoria.

> *"[the Victorian Bill] constitutes an unacceptable departure in our approach to human existence and the irrevocable sanctity that should govern our understanding of what it means to be human… What matters is the core intention of the law. What matters is the ethical threshold being crossed. What matters is that under Victorian law there will be people whose lives we honour and those we believe are better off dead. In both practical and moral terms, it is misleading to think allowing people to terminate their life is without consequence for the entire society. Too much of the Victorian debate has been about the details and conditions under which people can be terminated and too little about the golden principles that would be abandoned by our legislature."*[7]

Even though supporters of VAD maintain that VAD is about ensuring autonomy and control, it is extremely difficult to ensure that someone's decision to access VAD is free and autonomous. Pressure can be applied directly by other individuals.

No number of safeguards will protect the vulnerable against individuals of ill-will who are motivated to get around them. It is also well known that most of the abuse of the elderly comes from within the family. Doctors, even if they are well meaning can be subjected to pressure by family members of the vulnerable and dying. A 2011 survey of 800 family doctors in the Netherlands found that nearly half had felt "pressured by patients or their relatives" to use euthanasia.[8]

Pressure can also be applied indirectly. The fact that VAD would be an option applies some indirect pressure itself, as it will mean that VAD is one available option for someone's end-of-life choices. Palliative care will not be viewed as a necessity but rather a choice. The old person who now has the choice to select VAD may feel pressured over their 'selfish' choice to stay alive and be a burden to their families. Legalising VAD will apply pressure both directly and indirectly on the vulnerable to end their lives, either by choosing to die for the benefit for others or for the lack of better options.

Voluntary Assisted Dying Normalises Suicide

Normalising suicide as a legitimate end-of-life choice in European countries such as Belgium and the Netherlands has seen a dramatic increase in VAD in those countries along with a relaxing of the ease of access.

A 2012 Belgian report from the European Institute of Bioethics noted that after a decade of euthanasia, Belgian society was becoming desensitised to the seriousness of suicide and regarding it as a trivial matter.[9] Since legalising euthanasia in 2002, Belgium has steadily opened-up access to a broader range of patients suffering from mental conditions.[10]

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[7] Keating, Paul, "Voluntary euthanasia is a threshold moment for Australia, and one we should not cross" (The Sydney Morning Herald, 19October 2017) [redacted] last accessed 16/06/2021.

[8] Dutch News.snl, "One third of doctors have refused a euthanasia request" (29 Jul 2011) <https://www.dutchnews.nl/news/2011/07/one_third_of_doctors_have_refu/>, last accessed 29/06/2021.

[9] European Institute of Bioethics, "Euthanasia in Belgium: 10 years on" (April 2012) <[redacted], last accessed 29/06/2021, 7.

[10] Rachel Aviv, "The Death Treatment: When should people with a non-terminal illness be helped to die?" (The New Yorker, 15 June 2015) [redacted]>, last accessed 29/06/2021.

This is a far cry from the access that was originally usually only accessed by terminally ill cancer patients. Twelve years after the introduction of euthanasia laws in Belgium, the laws were relaxed to allow access to lethal injection to children of any age.[11] The numbers of deaths in Belgium by Euthanasia have been steadily growing. In the 5 year period between 2008 and 2013 alone the number of deaths increased by 250%.[12]

A similar trajectory has been documented in the Netherlands. Even though the Dutch law requires unbearable pain to be experienced, 20% of Dutch GPs surveyed said that they were willing to euthanise a patient who was merely "tired of life".[13] There have been documented cases of people being euthanised for mental distress and even the suggestion of creating mobile euthanasia units that can travel to euthanise patients whose own doctors refuse to do so.[14]

A society that legalises the state-sanctioned killing of the sick and dying will only find it easier to extend access to suicide to others who are vulnerable and despite their distress and situation, should never be able to take their own lives.

Overseas experience suggests that we cannot be certain that the proposed legislation will not be expanded to cover situations not originally envisaged. Queensland does not need to take this risk. The current state of affairs obviates the need for the *Voluntary Assisted Dying Bill 2021*.

CONCLUSION

The Voluntary Assisted Dying Bill 2021 must be rejected. It contains too many flaws, placing the care of the vulnerable and the conscience of health care workers in jeopardy.

The ACL strongly opposes the Bill and welcomes any opportunity to speak further on this very important issue.

WFrancis

Wendy Francis
Queensland and Northern Territory Director

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[11] Robert-Jan Bartunek, "Belgium Allows euthanasia for terminally ill children" (Sydney Morning Herald, 14 February 2014) [redacted] last accessed 29/06/2021.

[12] Commission Fédérale de Contrôle et D'évaluation, "De L'euthanasie Sixieme Rapport Aus Chambres Législatives" (Années 2012–2013) [redacted] last accessed 29/06/2021.

[13] Above no.8.

[14] Kate Connolly, "Dutch mobile euthanasia units to make house calls" (The Guardian, 1 March 2012) [redacted]>, last accessed 29/06/2021.