Submission into the Voluntary Assisted Dying Bill 2021

Submission No.:	1150
Submitted by:	Catholic Health Australia
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,Oversight and review
Attachments:	See attachment
Submitter Comments:	

Submission to the Health & Environment Committee *Voluntary Assisted Dying Bill 2021* (Qld)

July 2021

Executive summary

Catholic Health Australia (CHA) is grateful for the opportunity to comment on the *Voluntary Assisted Dying Bill* (Qld) (the Bill). We represent the largest grouping of non-government health and aged care services in Australia.

When our patients are dying, we strive to ensure that they die in comfort and with dignity. Consistent with this ethic of care, the Catholic health and aged sector will not take part in assisted suicide, or voluntary assisted dying (VAD).

Our stance has a strong ethical basis. Legalising VAD fundamentally undermines the role of clinicians to heal and not to harm. We fear the availability of VAD may steer vulnerable people away from seeking support and other treatment options. While the needs of the terminally ill person are at the centre, VAD also affects the rights of other people. The community of care within each of our hospitals and aged care facilities is centred on the inherent dignity of the human person. Passing the laws proposed for Queensland would expose people who have purposefully chosen to work with us because of our ethical stance to a practice that goes against their values.

The Bill itself is founded on a flawed premise: that Queenslanders have genuine choice about their end-of-life care. Thousands of Queenslanders cannot choose palliative care and, if VAD becomes law, will instead have the 'option' of ending their lives before time. The genuinely compassionate choice would be to fund universal palliative care, so that every person who wants and needs it can access it.

While we oppose this Bill in any form, we ask the Committee to, at minimum, recommend amending it. We have proposed changes that, if adopted, would offer better protection to vulnerable people, strengthen the accountability of practitioners, and protect the rights of hospitals and aged care residences to provide compassionate care, free of any exposure to VAD.

We believe terminally ill people deserve more protection than that offered by the laws proposed for Queensland. Our commitment to caring for the vulnerable, including the terminally ill, will never waver. We ask the Committee to offer Queenslanders a better choice.

Summary of recommendations

1. Fund universal access to quality palliative care
2. Refer any person requesting VAD to a palliative care specialist for assessment and discussion
3. Require either the consulting or coordinating practitioner to:
   a. hold specialist expertise and formal qualifications in the person's underlying disease, or
   b. refer the person to a specialist with training in their underlying disease, and
4. submit evidence of diagnosis and prognosis to the Voluntary Assisted Dying Review Board
5. Require consulting and/coordinating practitioners to:
   a. conduct a focussed VAD capacity assessment;
   b. where a person has a condition that could affect capacity, obtain an independent assessment by a relevant specialist;

Summary of recommendations

c. request and provide reasonable support for persons with issues that may affect capacity, including language support;

d. where a person has a condition that could affect capacity, obtain an assessment by a relevant specialist; and

e. provide evidence of capacity to the Review Board

6. Remove any obligation on non-residential facilities to provide access to a VAD practitioner

7. Permit non-residential facilities to make decisions concerning patient transfer at each stage of the VAD process

8. Require a person in a non-residential facility, or their practitioner, to inform the facility of any intention to seek VAD

9. Require a person in a residential facility, or their practitioner, to inform a residential facility of their intention to seek VAD

10. Allow residential facilities to provide the option of transfer, in consultation with the person

Who we are

CHA is Australia's largest non-government grouping of health, community, and aged care services accounting for around 15 per cent of hospital-based healthcare in Australia.

We promote the ministry of health as an integral element of our mission and work to provide compassionate care to the sick, the aged and the dying. This ministry is founded on the dignity of the human person, giving preference to the needy, suffering and disadvantaged.

Our members in Queensland include Centacare Brisbane, Mater Misericordiae Ltd, St Vincent's Health Australia, Francis of Assisi Home, Catholic Healthcare (including Villa Maria Ipswich and Fortitude Valley), Mercy Community Services, St Vincent's Community Services, Southern Cross Care, Ozcare, Holy Spirit Care Services, Mercy Community Services, St Vincent's Care Services, Canossa Services, St Paul de Chartres Residential Aged Care, St Vincent de Paul Queensland, Villa McAuley Retirement Village.

Between them they provide about one in five hospital and aged care beds in Queensland, including:

- 5,700 residential aged care beds
- 2,000 hospital beds
- 8,200 home care consumers.

Why we oppose VAD

In every health, aged care, and community facility, the people we care for and the people who provide care know our services will never take part in VAD. We know that people will continue to seek us out because of this. Our mission is to always care, never abandon, and never kill.

Consistent with this ethic of care, the Catholic health and aged sector will not provide, facilitate, or authorise anyone to support a person in our care to undertake VAD. This position is consistent with the Hippocratic Oath, and is shared by the Australian Medical Association and the World Medical Association.

There is a strong basis for our opposition to VAD.

- **The lawful practice of assisted suicide fundamentally undermines the role of physicians to heal and not to harm.** It erodes the trust between doctor and patient, as the patient may not be confident their doctor is acting in their best interests or pursuing every treatment avenue available. This is already the case in The Netherlands, where elderly people sign directives to ensure their doctors cannot coerce them into assisted dying or euthanasia1.
- **The availability of VAD, in and of itself, is subtly coercive**. People who may otherwise have enjoyed more time with their loved ones may see VAD as a mechanism of easing a burden on their families. People who lack family support or suffer from depression connected with their prognosis may seek out VAD instead of requesting and obtaining support to alleviate distress during their final days.

  This possibility is borne out by the experience in other jurisdictions where VAD is already lawful. Canada introduced VAD and euthanasia in 2016 and has published its first national report on the scheme[2]. More than a third of people dying by VAD or euthanasia in Canada cited a desire to not to be a burden as a reason for their choice, while a further 13% cited loneliness and the lack of social support as a factor[3]. Similarly, a systematic review found self-perceived burden was a problem for up to 65% of terminally ill people, and a contributing factor in the selection of death hastening pathways[4].

  At a time when mental ill health, social isolation and loneliness are on the rise, the Bill may have the unintended consequence of pushing people down the path of VAD. As with the experience in jurisdictions where VAD is available, many people accessing the scheme may do so for psychosocial factors unconnected with their comfort, pain or prognosis and which they should instead be supported through.
- **VAD affects the rights of others, not only the rights of the person seeking it.** In a hospital or aged care setting every patient or resident is part of a community of care. In the context of a Catholic run hospital or aged care facility, a value shared by this community of care is respect for the dignity of the human person. We offer terminally ill people a meaningful choice to be treated, live and die in a place where they know they will be cared for compassionately, without any coercion to opt for VAD. The Bill, as it stands, would undermine this ethic and force our hospitals and aged care organisations to facilitate VAD. In doing this, the Bill would force those thousands of individuals and their families, who have specifically chosen a Catholic facility because of its ethic of care, to live and die in a place where the practice of VAD may occur.
- **In jurisdictions where assisted suicide is legal, eligibility criteria have expanded over time:**
  - **Canada:** Medically assisted dying was introduced in 2016[5]. The scheme was strictly confined to those with an established terminal illness. The passage of Bill C-7 in 2020

[1] Sulmasy, D. P., Travaline, J. M., Mitchell, L. A., & Ely, E. W. (2016). 'Non-faith-based arguments against physician-assisted suicide and euthanasia'. *The Linacre quarterly*, *83*(3), 246–257, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5102187/>.
[2] Health Canada. (2019). *First annual report on medical assistance in dying in Canada*, report, accessed at https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf.
[3] Ibid.
[4] McPherson, C. J., Wilson, K. G., & Murray, M. A. (2007). 'Feeling like a burden to others: a systematic review focusing on the end of life'. *Palliative Medicine*, *21*(2), pp. 115–128, accessed at <https://journals.sagepub.com/doi/abs/10.1177/0269216307076345>.
[5] *Criminal Code*, RSC (1985), c C-46 s 241.2.

expanded the medical assistance in dying regime to any person experiencing a serious condition, including a psychiatric condition, which causes irremediable suffering[6].

- **The Netherlands:** The Netherlands was the first jurisdiction to legalise physician assisted suicide and euthanasia[7]. The laws have been progressively widened to people with mental ill health, patients with dementia who have previously provided consent, and children over one year of age[8].
- **Victoria:** Victoria was the first Australian jurisdiction to introduce VAD laws and eligibility is limited to people with a terminal illness[9]. While 224 people had died and 405 people had been issued permits under the scheme[10] by December 2020, by May 2021 assisted dying advocates were already campaigning to broaden access. The Chair of Victoria's Voluntary Assisted Dying Review Board has also argued that people diagnosed with a terminal illness should be proactively informed that VAD is an option for their treatment[11].

The Committee should consider the risk of 'mission creep' when introducing the proposed VAD Bill for Queensland. This is a genuine prospect when existing assisted suicide regimes have shifted the goalposts despite initially confining access to the terminally ill.

Areas of the draft laws that must change

Catholic Health Australia opposes the Bill in any form.

Our submission, however, must deal with the aspects of the Bill that are the most troubling to the rights of vulnerable people, our members, and the communities they support. We have highlighted these aspects below with proposals for amendment.

A real choice: the need for universal access to palliative care

No amendment will resolve our fundamental problem: that Queensland does not have universal, high quality palliative care. This means the Bill fails to offer real options to people approaching the end of life.

Palliative care provides a person living with a life-limiting illness to have the best possible quality of life. This outcome is achieved through a network of clinicians and care options which can include (but are not limited to) help with managing physical symptoms, psychological support, personal care, familial support, respite and support for family members[12].

Many Queenslanders, however, do not have access to high quality palliative care in their area or due to their age or condition. Palliative Care Queensland and the Australian Medical Association (AMA) Queensland have found providing every terminally ill person in Queensland with palliative care would

[6] Ibid.
[7] *The Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act* (2001).
[8] Government of the Netherlands. (2021). *Euthanasia, assisted suicide and non-resuscitation on request,* online article, accessed at <https://www.government.nl/topics/euthanasia/euthanasia-assisted-suicide-and-non-resuscitation-on-request>.
[9] *Voluntary Assisted Dying Act 2017* (Vic) s 9
[10] Victorian Agency for Health Information. (2020). *Voluntary Assisted Dying report of operations*, report, accessed at <https://www.bettersafercare.vic.gov.au/reports-and-publications/voluntary-assisted-dying-report-of-operations-july-to-december-2020>
[11] Kelsey-Sugg, A. and Barclay, P. (2021). 'It's been two years since Victoria introduced assisted dying laws, so how well are they working?', *ABC News*, online article, accessed at <https://www.abc.net.au/news/2021-05-07/voluntary-euthanasia-laws-how-well-are-they-working/100117058>
[12] Department of Health. (2021). *What is palliative care?,* online article, accessed at < https://www.health.gov.au/health-topics/palliative-care/about-palliative-care/what-is-palliative-care#:~:text=Palliative%20care%20is%20treatment%2C%20care,re%20likely%20to%20die%20from>.

require $275 million per annum in additional funding[13]. The Queensland Government's commitment of an additional $28 million per annum falls far short of this requirement.

This is even more concerning given the strong community support for guaranteed universal access to palliative care. **Table 1** summarises the results of our 2021 survey of Queensland voters[14]. The survey found that more than 94% of Queenslanders either strongly support or support providing guaranteed access to palliative care for people nearing the end of life.

Table 1: CHA survey of voter attitudes on palliative care

Table 1: CHA Survey of voter attitudes on palliative care					
	Strongly agree	Agree	Disagree	Strongly Disagree	Unsure/ Don't know
Should people who are nearing the end of their life have guaranteed access to palliative care to relieve pain and manage their symptoms?	85.80%	8.50%	1.20%	1.90%	2.70%
Do you agree or disagree that funding for palliative care should be increased so that it is more widely available to Queenslanders (including those in regional areas)?	78.00%	17.40%	1.60%	0.30%	2.60%

The Bill emphasises choice and states that a person requesting VAD must be informed of their options for palliative care[15]. The underlying assumption is that palliative care is an option for all Queenslanders. This assumption is not accurate.

The Queensland Government must fund universal access to palliative care. Only then can the Bill deliver on its promise to provide a genuine choice to terminally ill people.

Recommendation
1. The Queensland Government should fund universal access to quality palliative care
Changes sought
2. Refer any person requesting VAD to a palliative care specialist for assessment and discussion of treatment options

Ensuring accurate prognosis and availability of treatment options

One of the underlying criteria for selecting the VAD pathway is that the patient has a terminal illness[16]. Despite this requirement, neither of the two practitioners involved in assessing a person's eligibility to access VAD must possess specialist expertise in the patient's underlying condition. The practitioner

[13] Palliative Care Queensland, Australian Medical Association (Queensland). (2020). *Palliative care in Queensland: requirement for new investment to transform care*, report, available at <https://palliativecareqld.org.au/wp-content/uploads/2020/11/PCQ-QLD-Requirements-for-New-Investment-to-Transform-Care_Nov-2020-1.pdf>.
[14] Catholic Health Australia. (2021). *Survey of Queensland voters*, May.
[15] Voluntary Assisted Dying Bill 2021 (Qld) s 5(d)
[16] Ibid s 10(1)(a)

'may' refer to a consultant with specialist expertise but there are no criteria specifying when referral is required[17]. This means the decision to refer to a specialist or not is at the consulting and/or coordinating physician's discretion. A specialist trained in the patient's disease may never be involved in the VAD assessment.

While both practitioners are expected to keep and submit records to the Voluntary Assisted Dying Review Board, the Bill does not require that this information include evidence of the patient's diagnosis and the likely outcome of their condition.

These are significant omissions. Without the benefit of an assessment by an appropriate specialist, a person considering VAD may not be fully informed of their potential alternative treatment options. The prognosis itself may also be inaccurate. A patient with end stage cardiovascular disease should, for example, receive their prognosis and information about their treatment options from a cardiologist specialising in their condition. The Bill would allow doctors without this specialist expertise (notwithstanding their training in VAD) to assess the likely outcome of a patient's disease.

The Queensland Law Reform Commission's reasoning is that requiring specialist involvement would present people in rural, regional, and remote locations with a barrier to accessing VAD[18]. From a practical standpoint, this reasoning is flawed. Telehealth is widely accessible and provides a mechanism to conduct clinical assessments remotely. From an ethical standpoint, the need to ensure no-one is ever coerced or steered toward VAD should always outweigh the interest in ensuring greatest possible breadth of access.

The Bill should be amended to involve relevant specialists and for all practitioners involved in VAD to provide evidence of a patient's terminal diagnosis.

Changes sought

3. Require:
    a. either the consulting or coordinating practitioner to hold specialist expertise and formal qualifications in the person's underlying disease, or
    b. the consulting and/or coordinating practitioner to refer the person to a specialist with training in their underlying disease
4. Require that practitioners submit evidence of the person's diagnosis and prognosis to the Voluntary Assisted Dying Review Board

Stronger safeguards against coercion - Sections 11, 20, 32 and 46

In announcing the laws proposed for Queensland, the Premier stated that they include "a chain of safeguards to ensure only those at the end of life… and those capable of making that choice [of VAD'] for themselves"[19].

[17] Ibid ss 21 and 32

[18] Explanatory Notes, Voluntary Assisted Dying Bill (Qld), p. 16.

[19] Palaszczuk, The Hon. Annastacia. (2021). *Voluntary Assisted Dying laws introduced to Queensland Parliament*, media statement, accessed at <https://statements.qld.gov.au/statements/92172>.

This claim does not stand up to scrutiny. The Bill lacks the requirement for independent, rigorous assessment of capacity, and lacks specific protections for groups vulnerable to coercion or misinterpretation of their final wishes.

Section 11 provides for a presumption in favour of capacity to make decisions about VAD[20]. Characteristics such as language skills or a disability do not affect this presumption. While this presumption aligns with existing legislation (for example, the *Mental Health Act 2016* (Qld)), it fails to consider a key difference: the fact that VAD results in death. Determining a person's capacity to request VAD should not be treated in the same way as any other assessment about capacity. Assessing a person's capacity to end their life (and understand all the steps involved and their potential consequences) should have a higher bar than, for example, assessing their ability to enter a commercial transaction.

The process outlined for assessing capacity also exposes the vulnerable to risk. As mentioned earlier in this submission, two practitioners are involved in the assessment of a person's eligibility to access VAD. At various stages of this assessment, the practitioners must determine the person has the capacity to make decisions [21]. The Bill does not specify how VAD practitioners would make this assessment and does not require them to have any specialist ability in making these assessments**.**

The capacity assessment requirements of Netherland's assisted suicide and euthanasia[22] scheme are similarly unspecific. A recent analysis of the scheme found more than half (55) of all assessments relied on 'global' judgements of a patient's capacity[23]. Under a third (32%) relied on any evidence that a person demonstrated the four aspects of capacity[24].

The lack of strong checks and balances within draft VAD laws should be a concern given Queensland's rapidly ageing population. Dementia is the second most common cause of death for Queenslanders[25]. It is also a condition that can significantly affect capacity to make decisions. The training offered to medical students and General Practitioners (GP) in managing dementia is, however, severely limited: with the Royal Commission into Aged Care Quality and Safety hearing that the focus continues to be on acute and primary care[26].

Regardless of general or episodic capacity for decision making, the complex, multi-step and terminal nature of VAD requires a rigorous assessment of capacity. This assessment should focus on the ability of the person to understand and retain the information necessary for the decisions involved in VAD and their consequences.

At minimum, the Queensland Bill should include further safeguards, requiring the consulting practitioner to possess formal training and diagnostic tools to support capacity assessment. In the case of a person with an established condition affecting capacity (for example, dementia), the consulting and/or coordinating practitioner should obtain an independent assessment of capacity by a relevant specialist. The assessment should also include access to translation support where required. The

[20] Voluntary Assisted Dying Bill 2021 (Qld)
[21] Voluntary Assisted Dying Bill 2021 (Qld) ss 20 32 and 46.
[22] Assisted suicide refers to a doctor assisting a patient to end their life. Euthanasia refers to a doctor ending a patient's life with their consent and/or the consent of their family.
[23] Doernberg, S. N., Peteet, J. R., & Kim, S. Y. (2016). Capacity Evaluations of Psychiatric Patients Requesting Assisted Death in the Netherlands. *Psychosomatics*, *57*(6), 556–565, available at < https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5097685/>.
[24] Ibid.
[25] Australian Bureau of Statistics. (2019). *Causes of Death Australia,* accessed at <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/2019#australia-s-leading-causes-of-death-2019>.
[26] Counsel Assisting the Royal Commission. (2020). *Counsel Assisting's submissions on workforce,* Royal Commission into Aged Care Quality & Safety, February, accessed at < Counsel Assisting's submissions on workforce | Royal Commission into Aged Care Quality and Safety>.

consulting and coordinating practitioners should report the results of either assessment to the Review Board.

Changes sought

5. Require the consulting and/or coordinating practitioner to:
    a. conduct a focussed VAD capacity assessment; and
    b. In the case of a person with a condition that could affect capacity, obtain an independent assessment by a relevant specialist
    c. request and provide reasonable support for persons with issues that may affect capacity, including language support
    d. Require coordinating and consulting practitioners to provide evidence of capacity to the Review Board

Protecting the rights of institutions to opt out of VAD

If the Queensland Parliament is intent on legalising VAD it must respect the rights of institutions to take no part in it.

The Bill, however, would dismantle the ability of CHA members and other institutions to opt out:

- Hospitals ('non-residential facilities') must allow access to VAD practitioners from the first assessment right up to administration of a lethal substance. While a patient may be transferred at any stage of the process, the decision to permit or deny transfer rests with the VAD practitioner and not with the institution. In practice, this allows VAD doctors, unlike other clinicians, to have untrammeled access to our facilities. It would force Catholic services to refuse to accredit voluntary assisted dying practitioners or create an accreditation process that goes against the ethical standards we expect from everyone else.

- Aged care facilities ('residential facilities') must allow access to VAD practitioners and facilitate patient contact to and from a VAD practitioner. This is required from the first assessment right up to administration of a lethal substance. This would expose our members and other residents to VAD occurring on premises and facilitating VAD, without any other option.

These obligations also infringe the rights of the people working, living and being treated at our members' facilities. People who have intentionally sought to join a community providing compassionate care, free from any intentional taking of life, would be exposed to VAD. This exposure could be as a bystander (for example, witnessing someone undertaking VAD) or through unintentional participation in the practice (for example, through being handed a lethal substance).

These risks are compounded by the lack of any obligation to inform a hospital or aged care service that a patient or resident is intending to access VAD. Without this information, our members cannot act in the person's best interests by supporting them with information about other treatment and palliative care options. Our members cannot alleviate the fears (for example, about the loss of autonomy or being a burden) that may be steering them toward VAD. Our members also cannot fully protect others

at the premises from the VAD process, notwithstanding that they have chosen a Catholic facility precisely to be able to avoid this.

The Voluntary Assisted Dying Bill recently passed by the lower house in South Australia was amended at the Committee stage to reflect some of these concerns. The amended Bill provides non-residential facilities with the right to offer transfer at each stage of the VAD process.

The Queensland Bill should, at minimum, be amended to require that our facilities are informed that a person they care for is intending to seek VAD. It should also be amended to remove any obligation on our hospitals to provide access to VAD doctors and allow offer of transfer to a patient at any stage of the VAD process. The final decision to transfer should be the patient's in consultation with the facility and not the coordinating doctor's, which is the current presumption.

Changes sought
6. Remove any obligation on non-residential facilities to provide access to a VAD practitioner 7. Permit non-residential facilities to made decisions concerning patient transfer at each stage of the VAD process 8. Require a person in a non-residential facility, or their practitioner, to inform the facility of any intention to seek VAD 9. Require a person in a residential facility, or their practitioner, to inform a residential facility of their intention to seek VAD 10. Allow residential facilities to provide the option of transfer, in consultation with the person requesting

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