

Submission to the Health and Environment Committee

Topic: Voluntary Assisted Dying Act 2021.

I wish to respond to some of the aspects of the Voluntary Assisted Dying Act in my capacity as a general practitioner (GP) living in Toowoomba. I have lived and worked in Toowoomba since 1980. In my submission, I have divided it up according to the Chapters in the Full Report, not the clauses of the Bill.

Introductory Comment.

I wish to make the comment on the general premise of this bill that it is based upon a lie. The lie is that there is a difference between suicide and assisted suicide as generally understood (the latter still being a crime under the Queensland Criminal Code) and “voluntary assisted dying”. What can only be called a definition of convenience appears on Page 8 of the Report Summary where it says that:

“As the law currently stands, the self-administration of a substance to kill oneself, and which results in death is suicide. Persons, including health practitioners who assist that process of self-administration commit the offence of aiding suicide. Depending on the circumstances, a person who administers the substance at the person’s request may commit the offence of murder or manslaughter.

Voluntary assisted dying legislation alters that law in defined circumstances... Voluntary assisted dying laws provide that someone who ends their life in accordance with the process does not commit suicide and the health practitioners who assisted them to die are not liable for homicide or the crime of assisting suicide”.

Further on, on page 9 the report reiterates this by declaring that “If the assistance is authorised by legislation, then, in law, the death is not treated as a suicide and the health practitioner is not treated as having assisted a suicide”.

So according to this government which ordered the QLRC to produce a “bill for Queensland” to direct the introduction of euthanasia, it is not suicide because the state government has redefined what that word will mean from now on. One should not be surprised that a “law reform commission” should come up with such a tidy redefinition of an age-old practice born of desperation, despair or even a temporary loss of sanity. I wonder, does the government take us for fools? Does it believe that people, including doctors, can automatically adjust their consciences in accordance with a government dictum?

It is however particularly frightening that a government would support legislation to distort what is designed to be a life-preserving counterbalance to acquiescence in killing into a state prescription to be a permit to do that very thing.

As a citizen and a doctor, I take the proscription against taking life- one’s own or another’s- to be a very serious matter. I have always understood the purpose of the law to be a protection of everyone’s life equally regarding of one’s circumstances or how others may view the value of another’s life or human life in general.

It is also the ethic to protect human life that drives society to develop new ways to treat disease, to support people in suffering to hope for better health or support them in dying,

and to strive to respect all human life in general. It should not come as a surprise that if the law seeks to compromise on this endeavour by permitting and actively supporting assisted suicide in certain circumstances that the general public will view this as a weakening of intent to protect all human life.

Redefining something so basic and essential to the security of a citizen's life so that it is not considered to be killing of self or by another in circumstances determined by a government should ring alarm bells for every member of this committee because the responsibility for and consequences of this lie is being passed from the QLRC to yourselves.

Chapter 6: Initiating a Discussion about Voluntary Assisted Dying.

It is not an uncommon experience and duty of the medical profession to discuss the possible options for the management of a terminal illness once it has been diagnosed. In my experience, it is a difficult task for both the doctor and the patient, especially when dealing with 'unknowns'. Most doctors I know are very reluctant to give any firm life expectancy because we all know from our own or other's experience that it can be very wrong.

The discussion can also give the patient either the foreknowledge they need to make the required preparation or they may totally wish not to know, and any degrees in between these two positions. That often changes over time as acceptance sinks in. They will be in an emotionally vulnerable position, especially if they have few social supports. It is never right not to leave the patient with any hope, not necessarily of a cure but just of reassurance that everything that is reasonably available to them will be done.

Introducing an "option" of "assisted dying" should never be obligatory on the part of the doctor, although it is foreseeable that with the introduction of this legislation, it will become "the elephant in the corner" as many will know it is available. Doctors who know their patients well may feel very uncomfortable with any obligation to do this and indeed believe it is neither a duty nor a responsibility to suggest it. It has been some doctors' experience when other legislation (such as on abortion) changes to being freely available, there is an expectation of them from their professional bodies that they comply with the law rather than their conscience or even their patient's best interests.

It could actually be quite demoralising and psychologically shocking for a patient to have it suggested to them that they might like to avail themselves of a self- or practitioner-administered death, especially if it comes from a doctor with whom they have a long and trusting relationship. It could well seem quite insulting to the patient, if not undermine the doctor-patient relationship.

Even it remains permitted for a doctor to initiate the discussion, it should remain the doctor's prerogative and freedom NOT to have to do so, and not to be penalised for this.

Chapter 7: Eligibility Criteria.

1. Eligible Disease, Illness or Medical condition.

In this section I wish to comment on the provisions regarding mental illness and disability and access to this legislation. There is a wide range of such conditions and it is impossible to generalise about the impact it might have on the individual's resilience in the face of a terminal condition fitting the eligibility criteria. Many external factors, often beyond the

patient's control, such as level of social and emotional support, financial freedom, security of residency will play a role in the emotional state of the person at any particular stage of his/her illness. In summary though, such people are especially vulnerable to suggestions that they are "better off dead" as it is sometimes put. These people may have had many years if not a lifetime of living with their particular condition, and I have several patients in this situation. To add to this a terminal illness may be sufficiently demoralising in itself to make them feel suicidal or at least have a much diminished morale which makes them vulnerable to suggestion.

It is therefore highly neglectful **not** to see in this report **anywhere** the requirement for a **mandatory** mental health assessment should a patient with either of these issues in their past or present medical history apply for "VAD". It is my opinion that **every** applicant should have this done for them as a matter of course as part of the duty of care. It is even more vital it be done for people with a pre-existing mental health condition or disability.

This is also related to the "Level of Suffering" criteria used. To quote the draft report (page 31):

"Whether the person's suffering is intolerable is a subjective assessment, to be determined by the person requesting access to voluntary assisted dying...that suffering may include physical or mental suffering, or suffering caused by the treatment provided for that condition.

This approach recognises that suffering is a personal experience best determined by the person themselves, and that it may take various forms. It respects the person's autonomy, reflects a person-centred approach to care and is consistent with the value of reducing suffering".

These comments are valid if one is considering different approaches to treating a non-lethal illness or even applying palliative care for a terminal illness.

They are **not** valid when one of the options presented is "assisted dying". Having one's needs supported or be assisted to kill oneself or be killed are not equivalent treatments in most people's eyes.

The phrase "intolerable suffering" is also emotionally charged, extremely subjective and therefore difficult to challenge. Merely to accept at face value that intolerable suffering exists yet do nothing to diagnose the cause or alleviate it is not an exercise in respecting personal autonomy but medical nihilism and in any other context would be an example of medicolegal negligence.

The issue of referral to other medical practitioners for further opinions is covered later under Chapter 13.

3. Voluntary and Without Coercion.

The definition of coercion used in the Report (page 34) includes "threats, promises or intimidation of any kind including by improper use of a position of trust or influence" but does not include "proper and well-intentioned exercise of influence". That is all well and good for someone who is well positioned to exercise his/her freedom of choice, but it does

not take into account more subtle forms of influence such as societal and familial expectations.

A society in which assisted suicide is made legal and where the request for such is treated as a respectable and even positive choice in itself is not one which is going to be sensitive to subtle forms of coercion especially in people with low self-esteem or those more susceptible to influence from others, especially if they have become dependent on them for support of various kinds. Many elderly people are in that position and could not continue to live in their homes without support from family or friends.

This includes many elderly people who are also made to feel less worthy of time spent on them. As a GP, I commonly hear elderly people say to me that “I don’t wish to be a burden on my family”. This is not necessarily said in reference to euthanasia, but it is a very common sentiment. It is not difficult to see this arising from subtle elder abuse, whilst ‘inheritance impatience’ has become a growing problem.

Evidence from jurisdictions that have legalised assisted suicide or euthanasia show that coercion, including the feeling of being a burden on others is a very real problem e.g. data from Oregon showed that in 2018, more than one out of two people (54.16% or 91/157) who died after taking the prescribed substance had cited concerns about becoming a burden on family, friends or caregivers as a reason for the request. (1) Yet one of the first responsibilities of the physician under Oregon’s Act was to make the initial determination of whether the patient has made the request voluntarily.

In another example, in the state of Washington USA in 2017, 105 out of 196 people who died of assisted suicide cited concerns about being a “burden to the family, friends or caregivers’ as a reason for their actions. (2) In 2018 in the same state, of 203 applicants, 108 gave this as an “end of life concern”. (3) **It is highly significant that subtle coercion (real or imagined) should figure in at least 50% of cases.**

As a matter of interest, both states cite the following as “End of Life” concerns (in order of frequency-naturally more than one can co-exist):

1. Losing autonomy.
2. Less able to engage in activities making life enjoyable.
3. Loss of dignity.
4. Losing control of bodily functions.
5. Burden on family, friends/caregivers.
6. Inadequate pain control, or concern about it.
7. Financial implications of treatment.

In both Oregon and Washington, the law allows for a terminal illness likely to cause death within six months and a similar range of illnesses as those designated in the Bill for Queensland. Similarly, the majority of patients are elderly.

It is pertinent to ask at this point what procedures will be undertaken by the “coordinating” and “consulting” practitioners to ensure that coercion does not happen. The “tick a box”

approach stating they are acting voluntarily will surely not guarantee competence to establish this. It is highly likely that these doctors will have very little knowledge of the patient or his/her family or circle of support as they will be assessing other doctors' patients who will be largely strangers to them.

Chapter 8: The Request and Assessment Process.

I wish to make two points here.

8.128. The first is the requirement of a refusing practitioner to "refer on" to another practitioner or give details of an "assisted dying navigator service". Any referral even an indirect one, gives legitimacy to the purpose of this bill. Going beyond the provision of the Victorian legislation that doctors are not obligated to take any part in the request and application process is not necessary.

Secondly, the discussion on waiving waiting periods to less than nine days as recommended. Since applicants have had up to a year prior to their expected death to avail themselves of the law, it seems that waiting the minimum of nine days gives some protection against hasty decisions in the face of imminent death. I agree with some respondents to the enquiry who stated that:

"Less stringent obligations should not apply because a person is likely to die within the period, as this raises concerns about people making rash decisions or being forced into quick decisions against their will... there should be no reduction if the person is at risk of losing capacity as that can be a means to hurry them up with dying before their loss of capacity materialises". (8.468)

Another respondent said that it "will give space for people to have as many opportunities as possible to consider their decision, to reflect deeply upon their decision, to receive palliative care and process the complex array of emotions and grief experienced by the individual and their families and friends. This will also be an additional safeguard from external pressure to rush the process". (8.467)

It seems to have been presumed by much of the discussion that every applicant will have been considering euthanasia for a long time. However, that is not the case if a patient comes to the process late in his/her illness, becomes fearful of the 'dying process' and accesses the scheme out of a misplaced sense of urgency or panic that they will not qualify in time.

Chapter 10: Administration of the Substance.

The QLRC in the draft bill has come down on the side of two forms of administration- self and by a practitioner. I am concerned that in the case of self-administration, if the co-ordinating practitioner is also present, there is little guidance given to him/her should unforeseen events occur. This is covered under 10.205 where it says that "they will be able to provide comfort care in the manner they ordinarily would to a dying person and respond if any unexpected events arise".

This is in contrast to the Tasmanian legislation which is stated in 10.166 that in the event of "unexpected complications" either after the person or the administering practitioner has given the substance, there are instructions to be followed so that either the administering

doctor can give something else “that will enable the person to die more quickly and painlessly that would otherwise be the case” or indeed take action to preserve the person’s life”.

This begs the question of what is meant by unexpected events. In the previously quoted studies from Oregon and Washington state (see references 1 and 2), such events include a prolonged death, seizures, regurgitation and actually surviving the suicide attempt. In the 2018 report on the Washington State Dying with Dignity legislation, of 203 who died after ingesting the prescribed substances, 8 had complications such as those listed and in 16 cases it was unknown. It took 62 people more than 90 minutes to die and the longest was 30 hours. (3)

Unfortunately, the Victorian Voluntary Assisted Dying Review Board hasn’t seen it as important to detail in its report if any such events occurred (10.160). This omission is important because our draft legislation is being compared to other Australian legislation every step of the way. The QLRC considers that failed administration is not a reason for a practitioner to deliver (another) fatal dose (10.159).

Several points arise from this matter:

1. What steps with this committee take to make it clear to anybody accessing this legislation that failed attempts and other complications can and do occur (surely a matter of informed consent)?
2. What action can/should any medical or nurse practitioner in attendance take should such events occur? Can they use discretion and call an ambulance? What guidance will they be given?

Chapter 11: Management of the Substance.

There are three comments I wish to make here.

The first pertains to the event where a person may have applied for and obtained a lethal substance, but not used it after a year. The draft bill allows for a twelve month prognosis, thus providing more time for a change in the course of an illness, or changes of mind over the use of the substance but not having it surrendered it back to the contact person.

It is far from unusual for a person **not** to have died when expected. For instance, in the report on the 2018 operation of the Oregon Act, there was a range of 15-807 days between first request and death, with a range of 14-1009 days over the totals of years 2013-2018. (1)

From the report on Washington State for 2018, there is range of 2-115 weeks for 2018; 2-81weeks for 2017; and 2-112 weeks for 2016. (3).

This begs the question as to how long should the lethal substance remain in the possession of the person? And who is going to monitor that? If the contact person becomes unavailable to monitor the person e.g. through a change of residence, moving away from the locality, or some other circumstance not covered by the draft bill, not being simply a revoking of the contact person, whose responsibility is it to ensure someone else is appointed? If the person is still alive after twelve months, does he/she retain possession of the substance to use at a later time when capacity or coercion could not be ascertained?

The second point is the fourteen days allowed to return left over or unused substances after use. In 11.196, this stipulation is laid out and repeated elsewhere. However, considering all the other provisions around the notification of death (two days), it seems unnecessarily long to allow fourteen days. If the contact person or co-ordinating practitioner is aware of the death quickly, it should not take so long to organise to return unused or left over substances. This is a safety issue. The longer it is left, the more easily it can be misplaced or even interfered with.

The final point is an observation around the provision for supplying the substance in more regional and remote areas of Queensland. All efforts are made to expedite this as efficiently as possible, but the same government proposing this legislation has not made anywhere near the effort or expenditure required to offer an equal opportunity for palliative care services to be available to the same populace.

Chapter 12: Notification and Certification of Death.

It is argued in this section that the “cause of death” certificate and the official death certificate should list the cause of death as the illness itself which made the person eligible under the legislation and not use the words “suicide” or “assisted suicide” because of the social stigma associated with these words, for privacy reasons especially for the family and because it may impact upon life insurance and superannuation policies. Instead, in order to also assure that proper records be kept for data and medical planning purposes, the actual cause of death will be recorded by the Review Board.

With regard to the last two dilemmas, I see no reason why-if this Bill becomes law-that superannuation and Life policies could be negated by the method of death. Since the legislation applies to those who have twelve or less months to live, insurance companies cannot legitimately exclude people who are acting within the laws and bring about their deaths in the required time. In fact, it could well be deemed as discriminatory to refuse to pay out on the policy.

This Bill is already founded on the “principle” that it will not distinguish between natural death from a terminal illness and the action of administering a lethal substance to bring about death, as if it were one and the same thing. Many people beg to differ, and despite any distress brought about by disclosing the truth of the matter, it is still important in professional life and public policy to tell the truth.

This difficulty the Commission seems to have with the truth is particularly important when the patient is not nearing death e.g. he/she may still have some months to go before natural death would intervene, so that the **real** cause of the death is certainly not the illness itself. This is quite possible under the proposed scheme if the patient has completed the application process within a possible minimum nine days but yet could have some time left to live. There is no guarantee- and every legal possibility for it to be otherwise- that an applicant would choose to end his/her life anytime they wish once they have received the instruments of their death (“the substance”) after the paperwork is completed. In fact, exercising autonomy over the timing and place of one’s death is one of the chief purposes of this Bill.

Many people including doctors do not wish to be part of this deceitful process and believe their ethical and professional vows are totally negated by this falsification, whatever the law may permit them to do.

Finally, in respect to amending the Coroner's Act to also provide that deaths falling under the ambit of this legislation will not be "reportable deaths" for the purposes of the Coroner's Act, it is not hard to imagine how a crime could be disguised more easily as a "voluntary assisted dying" when assisted suicide itself is being legalised.

Suspected suicide is currently a reportable death. Even if the Review Board can still direct a suspicious death to be investigated, where will the incentive be for this when it is essentially a data collection agency? How is it going to determine from an office somewhere in Brisbane what may or may not constitute a suspicious death anywhere in the state?

Chapter 13: Health practitioners' Qualifications and Training.

Much of this chapter is devoted to argument over what and how many types of credentials and how many years of experience the coordinating, consulting and administering practitioners should have. In reality this isn't important as it is all designed to give a 'medical face' to what is simply a statutory process of approving a licence to kill.

Although the opinion of two doctors is arguably better than one, which is the case in Canada which has a serious escalation in their MAiD statistics, it is still the fact that even in the draft QLD bill, the "simple" case of application is that the coordinating doctor is also the doctor who gives the final approval and could easily also be the administering doctor in the case of practitioner administration. Except for the opinion of the consulting doctor, it is a "one man band". There are no mandatory provisions for referral for another opinion as it is left up to the judgement of either doctor.

Much faith is put in "general" rather than specialist practitioners to be the arbiters and predictors of a certain demise within 12 months, but no doctor has this infallible ability. Obviously the further progressed the disease is, the more one can be sure of the prognosis. But this Bill clearly allows for 12 months and the minimum time is 9 days from first to last consultation, or even less if it is considered that the patient will lose capacity before then.

There is also the potential that the coordinating and consulting practitioners are not independent of each other. For example, they may already have had a working relationship, the consulting practitioner has received referrals and feels pressure to agree with the coordinating doctor in order to continue the relationship.

This process is designed to expedite provision of death, not delay it or reconsider it, especially as is so many times repeated that regional and remote parts of Queensland do not have access to a variety of specialist opinions. The overwhelming impression from reading this chapter is to make it the application as simple and quickly available as possible. Much of the regular reporting to the Review Board is simply bureaucracy, not a safeguard.

What can only be described as chilling is the explanation why even nursing practitioners or registered nurses could be permitted to administer the lethal dose in 13.127 that

"There is no requirement for the (administering health practitioner) whether a doctor, specialist, nurse practitioner or registered nurse to diagnose anything".

In other words, there is no particular skill required to kill, they just need to do the required training to administer euthanasia.

As discussed previously, there isn't even a passing mention of the importance of assessing the mental welfare of any patient, especially but not exclusively someone who already has a history of mental illness. The role of disability in accentuating the difficulties posed by a terminal illness is also not mentioned.

It may be argued that this assessment will be achieved satisfactorily by the training process, but since it is acknowledged that Wilmot and White whose draft Bill is largely the substance of this Bill are also the people who wrote the training modules for the Victorian Government (13.174) and Western Australian government, it is by no means apparent that this will be a sufficiently rigorous process. The public or even medical professionals will not know what type of training is provided, who will determine the content and the providers of the training (much of which seems to be about the legalities of the process) until they actually become a part of the process.

Chapter 14: Participation by Individuals and Conscientious Objection.

As referred to "Values and Principles" (page 7 of the Report Summary) and in my comments for Chapter 13 above, the driving "principle" behind this legislation is the pursuit of autonomy in end of life decisions. This will inevitably cause a conflict with the many health professionals who consider that participation in any way with killing is not part of their job description.

I support the positions enunciated in 14.66 and 14.67 quoting the former, "a person should have uninhibited freedom to refuse to participate or should be able to refrain from involvement in accordance with their personal beliefs and values". I would also like to reference 14.133 which says, in relation to referral or transfer of care that:

"It would impact on a medical practitioners' morals or right to conscientious objection, where their objection extends to referring a person elsewhere to access a service... imposing an obligation on registered health professionals to refer is inappropriate. It imposes an obligation which some registered health professionals will consider to be a participation in an immoral act... obligations of this kind seriously undermine freedom of conscience and belief and elevate the legislative objectives set out (at 8.14) over the protection of that fundamental human right. It is an example of the "tendency to treat the right to freedom of religion or belief as less important and as a second-class citizen in the sphere of human rights".

The act of legislating such co-operation creates a crime not to comply regardless of whether a penalty is applied. It immediately subjects health professionals to scrutiny from APHRA if a complaint is made against them and thus threatens their right to practice and obtain a livelihood.

I also believe it will seriously impact upon the likelihood that doctors would even contemplate working in regional and remote areas as he/she will or could be the only doctor to be called upon.

The best alternative as enunciated in 14.134 is simply to allow doctors who have a conscientious objection to act in accordance with their beliefs and follow the general direction that they have a duty of care to the patient to advise they have a conflict of interest in the request, and then act in accordance with their personal beliefs in how far they go with a referral.

Chapter 15: Participation by Entities.

In its recommendations to the Committee, the QLRC has strongly favoured access to “assisted dying” over institutional conscientious objections, and in fact has gone further than any other state which has already legislated for this, dismissing in practice any objections to its practice on their premises should the condition of the person prevent their being moved, and in the case of permanent residents, prohibiting any denial of access whatsoever.

In so doing, they seem to be bent on causing an upheaval in the ranks of denominationally - inspired hospital and nursing home services (predominantly but not exclusively Christian), which provide a considerable bulk of the services in Queensland. They ignore the fact that many individuals who serve in these institutions do so because of a shared purpose in their statement of purpose or “mission statements”, even if they are not explicitly Christians themselves. In effect, they are denying these people their freedom of conscience also to work in a place where something as fundamental as human life is being taken. Doctors are not the only persons operating in health care who have a right to conscientious objection.

The QLRC has taken a very strong partisan attitude against religious liberty to the point of refusing to acknowledge that even if this state wishes to impose legislation on religion-based facilities which is inimical to their philosophy, they have no meaningful means of refusing this assistance. In effect, some member of the “navigator service” has right of passage to do anything to facilitate assisted suicide or euthanasia on their premises. This is really just a form of totalitarianism.

There is also no mention in this report (maybe because it has just been passed) that the South Australian legislation has a specific clause allowing such non- participation. In clause 10A (1) of the legislation, it says:

“A relevant service provider has the right to refuse to authorise or permit the carrying out, at a health service establishment operated by the relevant service provider, of any part of the voluntary assisted dying process in relation to any patient at the establishment (including any request or assessment process under this Act)”.

Clause 10A (2) says that:

“A relevant service provider may include in the terms and conditions of acceptance of any patient into the health service establishment an acknowledgement by the patient that the patient -

Understands and accepts that the relevant service provider will not permit the establishment to be used for the purposes of, or incidental to, voluntary assisted dying; and

Agrees, as a condition of entry, that they will not seek or demand access to voluntary assisted dying at the establishment. (Reference 4)

If this can be written into the SA legislation, it can also happen here. These profoundly felt obligations **not** to kill or participate in killing do not just affect hospitals and nursing homes. Palliative care institutions and hospices also have strong philosophical opposition to this type of legislation.

In conclusion, like Corona virus, legalisation of assisted dying and euthanasia is spreading like a plague and many members of Parliament will come under pressure to acquiesce to this for fear of seeming to be unsympathetic to dying people. I do not doubt the sincerity of people who have had sad and difficult deaths, nor their families who wish to avoid this for themselves. The true solution to this particular issue is not to kill the dying but to afford everyone who requires it the opportunity to enjoy best-practice palliative care services throughout Queensland.

It is also true though that much of the pressure for this legislation comes from those who wish to exercise autonomy in dying as a personal right. That is a totally different matter because there are very few matters in life over which we exercise total autonomy, and the law is there to protect everybody regardless of status and privilege. Many legislatures, for example in recent history in 2016 the United Kingdom, a similar demographic to us, rejected euthanasia because its parliament did not believe it could protect the more vulnerable members from its extension. The government concluded it would be impossible to ensure that vulnerable people did not feel they had a duty to die, and that every instance of euthanasia would be voluntary.

The majority of the countries or states of countries in the world do not have assisted dying legislation and it is not an inevitability that Queensland should have one either.

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