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Health and Environment Committee
Parliament House
George Street
BRISBANE QLD 4000

To Whom it May Concern

I wish to make a submission regarding the Draft Voluntary Assisted Dying Bill 2021. I write from the perspective of a doctor who has had approximately 10 years of experience, a significant amount of time of this has been in palliative care. I have had the opportunity to see palliative care provided both from a community and hospital setting. I feel well qualified and experienced to have an opinion on the topic and can provide valuable contributions to the conversation.

It is with great concern that I read the draft legislation "Voluntary Dying Bill 2021". Reading this legislation from someone with experience in the field I am convinced that it is heavily flawed. I appreciate the opportunity to make a submission and do so in good faith. My concerns are many, but I have chose to limit the topics that I would like to discuss as listed below.

I would like to express how the draft legislation fails in three ways:

1. The legislation fails to provide appropriate safeguards to prevent those that lack the ability to consent to have access to so called "voluntary assisted dying".
2. The legislation fails to respect current admitting and credentialling practises of hospitals and other healthcare facilities.
3. The legislation fails to provide adequate provision for conscientious objection.

Firstly, I would declare that the proposed safeguards as mentioned in the draft legislation offer no meaningful safeguards to those that do have capacity to consent or whose consent is swayed by coercion. As a doctor who has worked in palliative care for 10 years, I witness the vulnerability of patients who are in the terminal stage of an illness and am aware of the pressure that such people feel from all quarters at this time of their lives. The legislation requires that the doctor be convinced that the patient is not being coerced. It however offers no direction on how the doctor might come to the that opinion and the idea that a doctor could determine such a thing with accuracy is fanciful. Unfortunately, coercion is a ubiquitous experience of those in the terminal stage of one's illness. It is inevitable that patients will be coerced into suicide under this legislation, no one can reasonably deny this.

The draft legislation outlines a 3-stage process which claims that because the person perjures in expressing a wish to suicide that ensures that their wish is well established or at least no fleeting. The draft legislation initially states that the minimum of 9 days must pass from initial request to provision of a lethal substance for purpose of suicide. Immediately after requiring this minimum time period the legislation negates that previous requirement if there is a risk that the patient may lose autonomy. In which case no minimum time period is required. It seems to me odd that the legislation should go to lengths to create a process and claim that this is an appropriate safeguard only to offer a clause by which anyone can avoid the aforementioned minimum period of assessment. This is one of the many occasions within the legislation which demonstrates the bias towards having a patient suicide rather than protecting those that are vulnerable.

I also note that while the draft legislation excludes mental illness as a reason that one may be permitted to suicide that the presence of a mental illness does not exclude the person from access to assisted suicide. Mental illness is an exceedingly common comorbidity of terminal illness. It would be expected that more often than not, mental illness will be present. The legislation requires that the assessing health professional might be able to distinguish that the person's desire for suicide does not originate from their mental illness but rather from a reasonable desire, if such a thing exists, for suicide. This in my experience is impossible with any hope of accuracy. Rather I would expect that health professional would make an assessment upon if the health professional believes that suicide is a reasonable choice for the patient or not. So instead of the patient's autonomy being respected, the patient's autonomy would be replaced with the doctor's opinion that euthanasia should occur.

I note that coercing someone either towards or away from suicide is listed as an offence with the draft legislation with penalties attached. It is certainly true, as I have previously stated, that persons at the end of there lives bare pressure from people around them to act in one way or another. I am however sceptical whether it is possible to police those who might try to coerce someone to suicide. The practicalities of policing and convicting a person of such a crime I expect would make the law mute and ineffective.

On the contrary consider the provision which make coercing someone away from suicide also a crime, carrying maximum penalty of 7 years imprisonment. Consider that a doctor who it presented with a patient who is suicidal due to mental health is required by law, under certain circumstances, to employ the Mental Health Act 2016 to prevent them from suicide. I am also concerned how a doctor, who is concerned that the patient's expressed desire for suicide originates from a mental illness would navigate such a situation. On the one hand a doctor may be criminally negligent for not treating suicidality and on the other be guilty of an offense if they do. As such treatment is deemed to be a form of coercing the patient away from suicide. There appears to be an assumption that determining the source of a person's desire for suicide is a straightforward exercise. It is clearly not and leaves that doctor at risk of prosecution is he or she fails to make the correct determination. Upon my reading the topic I do not hear this concern raise. I think that a conflict between the Mental health act 2016 and this draft legislation Voluntary Assisted Dying 2021 is a real concern that has not received attention.

I would like to echo one of our Ex-Prime ministers Paul Keating who declared that the idea that one can legalise the intentional ending of one's life and continue to protect these people

in there vulnerability as “bald utopianism”. The measures that are suggested in this draft legislation are clearly tokenistic. There is a clear bias toward suicide and a lack of interest in protecting the vulnerable who feel coerced to suicide.

Secondarily I would like to address a component of the legislation which requires hospitals and residential facilities to the allow access that those that might facilitate suicide if the patient cannot be reasonably moved or if it is the patient’s typical residence.

One such consideration is regarding the credentialing and admitting rights that facilities require prior a health profession undertaking care of patients with a given facility. Facilities typically require that prior to undertaking work within a facility that the facility is satisfied that the health professional is in good standing and is given a scope of practise within which to work. Doctors and other health professionals typically undertake significant scrutiny to see that they are suitably trained. This legislation it appears bypasses this practise for the purpose of assisting suicide. The legislation allows that facility no right to even question the doctors’ qualifications or standing but rather must permit entry without exception. I know of no other situation where a health professional is given such little oversight and where the facility is so disenfranchised to ensure good care of the patient/resident.

Another consideration which is a further means by with the facility is disenfranchised is that many of these facilities are church and community organisations that are in principle opposed to suicide and cannot permit such acts to knowingly happen in their facilities. This legislation as drafted would require these facilities to compromise their values, sell, shut down or otherwise undertake civil disobedience. These organisations play an important role in our society and should be not marginalised but rather supported in their mission of caring for the sick and elderly.

Thirdly the legislation fails to provide adequate provision for conscientious objection. The legislation as drafted is disingenuous where at times claiming conscientious objection is permitted and then requiring a health professional to assist that person by providing contact information to someone who will provide assistance in suicide. As such an assistance would consist of material cooperation with the act of suicide it is unclear how the act can claim to offer conscientious objection provision. I would also like to draw attention to the fact that while it is claimed that health practitioners are offered conscientious objection no provision is even pretended for administrative or operational staff.

In summary I wish to declare that the draft legislation as it stands is heavily biased toward to provision of suicide with little regard to protecting vulnerable patients. It does not address the concerns of the non-government facilities within which many terminally ill people are cared for. This legislation is disingenuous in declaring that conscientious objection for doctors will be respected and offers no protection for other workers within the healthcare facilities.

Yours Sincerely

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