

Submission on the Voluntary Assisted Dying Bill 2021

Health and Environment Committee,
Parliament House, BRISBANE

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Summary

This brief submission will deal only with the two grossest defects in the Bill:

1. The Bill's contempt for conscientious objection, whether of individuals or associations of individuals.
2. The Bill's neglect of three essential conditions if a patient is to give informed consent to be killed.

I reiterate my critique of this Bill as a whole: that the enshrining of intentional killing in medical practice shatters the cornerstone of law and of medicine; it demoralises the field of palliative care (in which I have long worked and taught); it institutes a new cultural oppression of the most vulnerable, which no regulation can prevent; it normalises suicide as an acceptable solution to suffering, with reckless indifference to troubled youth and depressed individuals.

I am available to speak further with the Committee.

1. The Bill's contempt for conscientious objection, whether of individuals or associations of individuals.

I must assume good will on behalf of the framers of this Bill. Therefore, I ask that they show good will by removing the malevolent element in this Bill that would compel material cooperation by conscientious objectors in the grave evil of intentional killing.

It is clear from the Explanatory Notes that the framers see no grave evil in the act of one person intentionally killing another, or of one person providing the means for another person to kill himself or herself. That is a value judgement of the framers which is novel and revolutionary, contradicting thousands of years of law and medical ethics.

“Society’s prohibition of intentional killing is the cornerstone of law and social relationships”, as the House of Lords Select Committee on Medical Ethics put it, in their landmark enquiry rejecting euthanasia.¹ This Bill shatters that cornerstone of law.

“Doctors should not be involved in interventions that have as their primary intention the ending of a person’s life,” as the Australian Medical Association stated in 2016,² supporting the World Medical Association’s opposition to euthanasia and physician-assisted suicide. This Bill directly opposes the AMA’s and WMA’s ethical position and clinical guidance.

The framers of this Bill are entitled to their novel and revolutionary opinion and to so legislate that those who share their values can access euthanasia and assisted suicide. However, on the higher human-rights grounds of freedom of conscience and association, the framers of this Bill are not entitled to force their moral opinion upon those who consider intentional killing and assisted suicide to be grave evils.

Lawmakers should not contemplate using the force of law to compel the conscience of fellow citizens. Jennifer Jackson in the 2006 textbook, *Ethics in Medicine*, writes that it is “a hallmark of civilised society that we exercise tolerance towards people with whom we disagree deeply on moral or religious matters ... that we find ways to avoid forcing people to disobey the dictates of their conscience”.³

Conscience is a non-negotiable element in the integrity of any person who would be a doctor or nurse. Crush the conscience of a doctor or nurse and you will end up with a diminished and disintegrated person as your confidant and healer.

There are indeed ways in this Bill “to avoid forcing people to disobey the dictates of their conscience” on the gravest possible matter of conscience: the act of intentional killing:

¹ House of Lords, Report of the Select Committee on Medical Ethics, 1994 HMSO.

² AMA Position statement on euthanasia and physician assisted suicide, 2016, <https://ama.com.au/system/tdf/documents/AMA%20Position%20Statement%20on%20Euthanasia%20and%20Physician%20Assisted%20Suicide%202016.pdf?file=1&type=node&id=45402>

³ Jackson J, *Ethics in Medicine*, Polity Press Cambridge 2006, quoted in Gerrard JW, Is it ethical for a general practitioner to claim a conscientious objection when asked to refer for abortion? *J Med Ethics* 2009;35:10 599-602

i. To avoid forcing the conscience of the individual doctor or nurse:

Recommendations:

- **Delete 84 (2) (b)**

This will leave the requirement 84 (2) (a) that a conscientiously objecting doctor “inform the person that other health practitioners, health service providers or services may be able to assist the person”.

While it is doubtful that such a statement tells the patient anything they (or their family and friends) do not already know, such a statement is ethically neutral: it does not usher the patient along the path towards the gravely evil act of intentional killing or assisted suicide.

By contrast, 84 (2) (b) *does* usher a patient along that path and should be removed from the Bill. No doctor who considers intentional killing and assisted suicide to be gravely evil acts should be compelled by law to “give the person information about a health practitioner or service (including name and contact details) who, in the practitioner’s belief, is likely to be able...” to commit that gravely evil act.

If the framers do have good will on the matter of conscientious objection and are not just exercising raw power to force their values down other people’s throats, then this draft provision 84 (2) (b) will go.

ii. To avoid forcing the conscience of the association of individuals who construct an “entity”, a caring institution, around a set of moral values

Recommendations:

- **Delete subdivisions 1, 2, 3 of Division 2.**

Subdivisions 1,2,3 of Division 2 amount to an assault by state power on the moral structure and ethos of care of church institutions. It is an assault on the conscientious liberty of every member of these values-based associations.

- **Keep subdivision 4 of Division 2 (98)**

This is a clear advertisement to consumers that this entity does not provide ‘VAD’ and should be required in the interests of informed consent in seeking admission to such a facility.

These “entities” include church foundations such as hospitals / nursing homes / hospices, which are an extension of the moral community that built up those “entities” over generations. Such an “entity” is an expression of the two fundamental liberties of conscience and association, and this Bill would trample on both liberties.

Church hospitals / nursing homes / hospices run according to an ethos of care which utterly rejects intentional killing. This Bill compels such “entities” to allow intentional killing and

assisted suicide to take place on their own private property, in defiance of the ethos of care that governs the hospital / nursing home / hospice.

These “entities” would also include a community hospice formed around the ethos of palliative care, which precludes intentional killing.

The “coordinating practitioner” is given the unchallenged power under this Bill to determine that a person *will remain* at one of these institutions and receive euthanasia / assisted suicide, even where those who run the institution have duly advertised under Subdivision 4 that such an act is *not available*, and duly ensured that all patients / residents have accepted that non-availability as a condition of care at that institution.

How is that just and fair?

The Bill should be amended to remove any such dictatorial discretion of the “coordinating practitioner” – who may be a very junior doctor with no visiting rights at that hospital or nursing home but who still overrules the institution’s ethos, policy and management.

Instead, the Bill should accept the normal principles of non-availability of a service in a private institution, as determined by the service provider and duly advertised so that all clients have duly consented.

The onus is then on the patient or resident, should they decide to seek out a “VAD service” *that they know is not available* at that “entity”, to seek transfer to another institution (e.g. public hospital, government-run nursing home).

It is not unethical for the church institution to assist compassionately with such a transfer, provided no direct referral for VAD is required, only the neutral provision of the patient’s medical information.

2. The Bill’s neglect of three essential conditions if a patient is to give informed consent to be killed.

I assume that the framers are sincere in their stated objective to ensure proper informed consent to the act of being killed or aided in suicide. Therefore, I make the following three clinical points, which would need to be addressed if that stated objective is to be taken seriously:

1. **Without specialist psychiatric assessment**, there can be no confidence in the Explanatory Notes’ objective (p.5) “to ensure a person has decision-making capacity”.

Such capacity may be profoundly affected by depression, dissociative states or any of the subtle and profound mental aberrations that so often occur under the pressure of major physical illness, powerful medications (with the attendant side

effects on mood and cognition), and the emotional / existential turmoil of a terminal diagnosis.

Major depression is an abnormal state of the brain that doctors have a duty to identify and correct, yet depression is very difficult to distinguish from the grief and hopelessness of a terminal patient's situation. Specialist assessment is vital if valid consent is to be given by such patients.

This Bill has no requirement for specialist psychiatric assessment. It allows for any medical graduate of a mere five years' experience (perhaps two years as a junior hospital officer and three years as a trainee GP) to judge that a person's cognitive capacity and mood is not affected as above. That is a trivial, indeed negligent, response to a challenging clinical reality. It makes a mockery of the stated objective in the Explanatory Notes: "to ensure a person has decision-making capacity".

2. Without specialist palliative care assessment, likewise, there can be no informed consent to end one's life prematurely.

This Bill has no requirement for specialist palliative care assessment. The same inexperienced doctor described above, perhaps two years as a junior hospital officer and three years as a trainee GP, would have very little knowledge of this complex and powerful speciality and would not necessarily be aware of his own ignorance – therefore, he could give the required "advice" under the Bill and tick the palliative care box.

Again, to allow euthanasia / assisted suicide to proceed without the priceless input of a palliative specialist is a trivial, negligent, response to a challenging clinical reality. It makes a mockery of the stated objective in the Explanatory Notes: "to ensure a person makes choices that are informed about other end of life options, such as palliative care".

3. Without assessment by a specialist in the field of the patient's illness, likewise, there can be no informed consent to end one's life prematurely.

This Bill has no requirement for assessment by a specialist in the field of the patient's illness. The same inexperienced doctor described above might have little knowledge of the many and varied terminal conditions presenting under this Bill and would not necessarily be aware of her own ignorance – therefore, she could give the required "advice" under the Bill and tick the "further treatment" box.

Again, to allow euthanasia / assisted suicide to proceed without the required input of a specialist in the field of the patient's terminal illness is a trivial, negligent, response to a challenging clinical reality. It makes a mockery of the stated objective in the Explanatory Notes: "to ensure a person makes choices that are informed about other end of life options, such as further treatment".

Thank you for your consideration of these grossest defects in a Bill which will shatter the cornerstone of law, corrupt the medical profession with a power we should never be given, demoralise the field of palliative medicine through the toxic imposition of an alien ethos of care, and usher in a new, undetectable and unpreventable form of elder abuse.

I am available to talk further with the Committee.

Yours faithfully,

Dr David van Gend

