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FAMILY
ASSOCIATION**

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Committee Secretary
Health and Environment Committee
Parliament House,
BRISBANE QLD 4000

Emailed to: hec@parliament.qld.gov.au

Re: Inquiry into the Voluntary Assisted Dying Bill 2021

Summary

The Australian Family Association appreciates the opportunity to make a submission to the Health Committee inquiry into the Voluntary Assisted Dying Bill 2021.

The Australian Family Association has been in existence for more than 40 years. We provide a forum and a vehicle for those individuals and organisations in the community concerned with the strengthening and support of the natural family. We are a voluntary, ecumenical and non-party-political organisation.

As instructed, we will confine our submission to aspects of the Bill, even though we are totally opposed to killing by assisted suicide and euthanasia and therefore to the Bill as a whole.

Our submission recommends:

1. That the Bill be amended to **provide far more stringent safeguards against many wrongful deaths** that otherwise would occur if the Bill was legislated in its current form.
2. That the **conscientious objection provisions of the Bill be amended** so that both individuals and institutions will not be made to be complicit in the act of killing, in the case of individuals by being forced to refer, and in the case of institutions by being compelled to allow the act of killing to be done on their premises.
2. That **funding for palliative care in Queensland be boosted substantially by \$247 million a year**, as called for by Palliative Care Queensland, so services can be expanded, particularly in the regions, in order that all terminally patients can choose to receive the end-of-life care to which they are entitled as a fundamental human right.
3. That the Queensland Government **implement a long-term educational advertising campaign educate the public about palliative care** and its ability to ease the dying process in relieving pain and caring not only for patients but also for their families.

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1. Introduction

The Explanatory Notes state that among the main purposes of the Bill are:

- To establish safeguards to:
 - ensure that the [VAD] process is accessed only by persons who are assessed to be eligible;
 - protect vulnerable persons from coercion and exploitation; and
- To provide legal protection for health practitioners who choose... not to assist persons to exercise the option of ending their lives in accordance with the Act.

Yet this Bill fails miserably in achieving these goals.

2. The Bill's Lack of Effective Safeguards

Some proponents of legalising assisted suicide or euthanasia are honest enough to admit that it is the case that wrongful deaths will occur.

Dr Henry Marsh, a noted British neurosurgeon and champion of assisted suicide, famously said: "Even if a few grannies are bullied into committing suicide, isn't that a price worth paying so that all these other people can die with dignity?"

This is the question that any responsible legislator considering this issue needs to ask.

Your duty as members of Parliament is to legislate for the greater good of the community.

Before you rush in where "angels fear to tread" in the name of autonomy and choice, we suggest you ask yourselves why only eight nations out of the 195 countries in the world and just eight states out of 50 in the USA have legalised either assisted suicide or euthanasia.¹

For example, why has the UK Parliament rejected euthanasia legislation so far?² And here in Australia, why did the South Australian Parliament reject assisted suicide and euthanasia legislation 16 times over 26 years?³

And why have all seven Australian Prime Ministers from both sides of politics over the last 30 years, including Labor PMs Keating, Rudd and Gillard, opposed the legalisation of assisted suicide and euthanasia.

In 2017, **Paul Keating warned of the pressure legalising assisted suicide and euthanasia would put on people to choose to die prematurely to relieve their family of the burden of care:**

"It is commonplace for patients to tell doctors in front of their loved ones that they have no wish to be a burden on families.

¹ https://en.wikipedia.org/wiki/Legality_of_euthanasia

² https://en.wikipedia.org/wiki/Assisted_suicide_in_the_United_Kingdom

³ <https://www.9news.com.au/national/voluntary-euthanasia-bill-south-australia-parliament-assisted-dying-closer/923c46c6-a64f-43aa-b76e-849c0e4687f7>

“Once this bill is passed the expectations of patients and families will change. The culture of dying, despite certain and intense resistance, will gradually permeate into our medical, health, social and institutional arrangements. It stands for everything a truly civil society should stand against.

“A change of this kind will affect our entire community not just a small number of dying patients. It is fatuous to assert that patients will not feel under pressure once this bill becomes law to nominate themselves for termination.”⁴

And in 2011 Julia Gillard warned that legalising assisted suicide and euthanasia may "open the door to exploitation and perhaps callousness towards people in the end stage of life" and that she was not convinced that the policy of pro-euthanasia advocates contained "sufficient safeguards".⁵

The proper tests for a law permitting assisted suicide or euthanasia are the ones that are usually applied to any proposal to reintroduce capital punishment:

“Can we craft a law that will ensure there will not be even one wrongful death?”

“Can we ensure that any deaths under this law are humane – that it is both rapid and peaceful?”

In order to inform yourselves of the risk of wrongful deaths inevitably associated with any state apparatus of killing, **attached** as an Appendix to this submission is a 44-page report detailing Eleven Categories of Wrongful Deaths by Assisted Suicide or Euthanasia, produced by Australian Care Alliance.

When it comes to safeguards, the current Queensland Voluntary Assisted Dying Bill is seriously deficient in at least three aspects:

1. The Bill does not require a patient requesting assisted suicide or euthanasia to have a prior consultation with a specialist in their disease to determine whether his or her symptoms could be ameliorated.
2. The Bill does not require a patient requesting assisted suicide or euthanasia to have a prior consultation with a palliative care specialist to determine whether his or her pain and suffering could be reduced.
3. The Bill does not require a patient requesting doctor-assisted suicide to have a prior consultation with a psychiatrist to determine whether he or she is competent and whether his or her depression should be treated. How on earth can vulnerable terminally ill patients make a free and informed choice when many of them would be suffering from untreated depression?

Amazingly, in the name of access, two GPs will do. No specialists required here, as apparently this life-or-death decision is not important enough to warrant their involvement.

Under this Bill, how will the Queensland Government guarantee that vulnerable terminally ill patients are competent and are making an informed choice when an early death can be suggested to them legally by their trusted doctors or nurses who are caring for them, without any input being required from a specialist in their disease (for example, their oncologist in the case of a cancer patient), a palliative care specialist and a psychiatrist?

It is also outrageous that medical professionals can suggest assisted suicide or euthanasia to any terminally ill patient under this Bill, even in the context of other end-of-life choices. Other Australian jurisdictions which have legalised assisted suicide and euthanasia have not allowed this conversation to be initiated by a doctor or nurse, for very good reason.

⁴ “Voluntary euthanasia is a threshold moment for Australia, and one we should not cross”, Sydney Morning Herald, 19 October, 2017

⁵ Kelly, Paul (21 March 2011). "PM offers no hope to social Left". The Australian

It is disgraceful that the Bill would allow a terminally ill patient to request assisted suicide or euthanasia on the basis of "intolerable suffering" which is just mental or emotional, not strictly physical.

This would allow patients to request assisted suicide or euthanasia soon after they are given their prognosis of 12 months or less, out of fear of future pain, while they are still in shock from the news.

Furthermore, the provision in the Bill to allow patient to request assisted suicide or euthanasia 12 months out from their expected death, when every other Australian jurisdiction which has legislated this has allowed this request to be made only six months out, is the height of folly.

Given the mistake rate by doctors in diagnosis and prognosis is around 10% (see Appendix to this submission), allowing a request for assisted suicide or euthanasia 12 months out certainly will lead to more wrongful deaths than would be the case with a six-month window. After all, how many people do we know who have outlived their cancer prognosis by years and enjoyed extra quality time with their families?

You cannot allow this Bill to be voted on as it is, unamended. The importance of extra safeguards to protect the elderly, ill and infirm is paramount in a civilised society.

This is because the law changes culture, and therefore this Bill would put the vulnerable at extra risk. This is best illustrated by the UK legislative review experience.

The UK House of Lords Select Committee on Medical Ethics in 1994, was chaired by Lord Walton, who was the patron of the Voluntary Euthanasia Society, yet after visiting the Netherlands and seeing first-hand the abuses there, it unanimously arrived at this position:

"Ultimately, we concluded that none of the arguments we heard were sufficient to weaken society's prohibition of intentional killing, which is the cornerstone of law and social relationships. Individual cases cannot establish the foundation of a policy which would have such serious and widespread repercussions."

The Select Committee's main concern was about the injustice euthanasia would cause if it were legalised. The Committee stated: "It would be next to impossible to ensure that all acts of euthanasia were truly voluntary. **We are concerned that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death. We believe that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life.**"

Unfortunately, it seems that the activists who agitated for this dangerous Bill and its drafters at the Queensland Law Reform Commission do not care about wrongful deaths and view effective safeguards as simply barriers to access.

As members of the Health Committee, you have the ability to try to limit the harm this extreme law (the most permissive in Australia) will do by recommending amendments for the above safeguards to Parliament, and we would urge you to act for the greater good of the community and do that.

3. Conscientious objection clauses need to be expanded

The conscientious objection provisions of the Bill need to be amended so that both individuals and institutions will not be made to be complicit in the act of killing, in the case of individuals by being forced to refer, and in the case of institutions by being compelled to allow the act of killing to be done on their premises.

This is not a full conscientious objection. If it remains, it will drive many good doctors and nurses who value life out of the medical profession.

Patients going into church-run hospitals, hospices and aged care facilities know the ethos of these institutions when the decision is made to apply for admission.

It would not be just to force these institutions to allow outside doctors to come on to the premises to kill their patients.

4. Palliative Care – a fundamental human right for all towards the end of life – urgently needs to be properly resourced

The definition of palliative care by the World Health Organisation (WHO) is:

Palliative care is an approach that improves the quality of life of patients **and their families** facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (emphasis added).

Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative care is delivered by teams of specialist doctors and nurses, as well as accredited GPs, aided by psychiatrists, psychologists, physiotherapists, counsellors, social workers and chaplains.

Depending on the disease, oncologists, neurosurgeons and respiratory physicians may be consulted.

Other allied health professionals who may be part of the team include: dietitians, music therapists, occupational therapists, orthotists and prosthetists, pharmacists, podiatrists and pastoral care workers.

Palliative care is delivered in hospices, hospitals, aged care facilities and at patients' homes.

The founder of the palliative care movement, Dame Cicely Saunders, a nurse who became an eminent doctor, researcher, medical administrator, fundraiser and publicist, opened the first modern hospice, St Christopher's, in London in 1967. She knew that care for the dying was not simply a matter of managing patients' pain, so she developed a theory of "total pain" which encompassed its emotional, social and spiritual elements.

"The whole experience for a patient includes anxiety, depression and fear: concern for the family who will become bereaved; and often a need to find some meaning in the situation, some deeper reality in which to trust," she said.⁶

⁶ Michael Cook, *The Great Human Dignity Heist: How bioethicists are trashing the foundations of Western civilisation* (Connor Court Publishing, 2017), p.57.

The loudest voices in today's debates over euthanasia are often its champions, doctors whose credentials include public defiance of the law by killing depressed and lonely patients. But in the long run, it will probably be the softer and more humane voice of Dame Cicely Saunders who helped thousands to a peaceful death: "You matter because you are you, and you matter to the last moment of your life."⁷

In 1990, WHO's expert committee report, *Cancer Pain Relief and Palliative Care*, stated: "... with the development of modern methods of palliative care, legalisation of voluntary euthanasia is unnecessary. Now that a practicable alternative to death in pain exists, there should be concentrated efforts to implement programs of palliative care, rather than a yielding to pressure for legal euthanasia."⁸

It should be pointed out that palliative care has made great advances since 1990. Yet it is still under-utilised, largely because of the lack of resources caused by government underfunding and sometimes ignorance by medical professionals who should know better but persist with active measures to extend life rather than focussing on relieving symptoms.

An Australian palliative care expert, Dr Brian Pollard, wrote in 1994: "In medical practice, it is *never* necessary to kill a person to relieve physical pain."⁹

In 1999, two American ethicists pointed out: "Physicians have at their disposal today the means to adequately control the pain of virtually every patient who is terminally ill... Hospices specialise in the art of pain control, particularly for the terminally ill. Far too many people die in hospitals, pursuing aggressive care, when they could be spending their last days with their pain under control, their depression (from being terminally ill) being treated, and not subject to expensive and burdensome aggressive medical technology."¹⁰

It is the stories of these cases that we hear from those traumatised by these experiences crying out for euthanasia, unaware or dismissive of the much better alternative end of life care that palliative care offers, if properly resourced.

In oral evidence on 5 April, 2019, Dr Peter Whan, told the previous Health Committee in 2019 that he was the only palliative care specialist for the Central Queensland Health and Hospital Services, in a population of 400,000 people over 200,000 square miles, when the guidelines say there should be 8 such specialists. We understand that he has since retired, so presumably there is now not even one palliative care specialist assigned to central Queensland.

Dr Andrew Broadbent, the palliative care specialist for the Gold Coast HHS, gave an example to the previous Health Committee in 2019 of a teenage patient with cancer who could not be treated with complex pain relief in Queensland who had to go to Lismore in NSW to access the necessary treatment.

We note the written submission to the previous Health Committee in 2019 from the Qld Specialist Palliative Care Services Medical Group, which states on Page 3: "Death is a universal health outcome. Equitable access to comprehensive palliative care, therefore, must be recognised as a fundamental human right and an essential component of value-based safe and high-quality health care for all. It cannot and should not be considered an optional extra of any health service."

⁷ Ibid, p. 61

⁸ WHO, *Cancer Pain Relief and Palliative Care*: report of a WHO expert committee (Geneva: World Health Organisation, 1990): WHO Technical Report Series 804, p. 11

⁹ Brian Pollard, *The Challenge of Euthanasia* (Sydney: Little Hills Press, 1994), p. 174

¹⁰ Scott B. Rae and Paul M. Cox, *Bioethics: A Christian Approach to a Pluralistic Age* (Grand Rapids, Michigan: William B. Eerdmans, 1999), p.246.

The submission stated that “the total funded full time equivalent (FTE) palliative medicine specialist positions in Queensland are 38.4FTE positions while the required FTE positions equate to 92.94 FTE positions”.

This indicates that funding for palliative care in Queensland needs to be more than doubled.

This under-resourcing of palliative care by the Queensland Government is a disgrace. Steps need to be put in place immediately to remedy this scandalous situation.

The peak body Palliative Care Queensland worked with the sector and AMA Queensland to come up with a funding model for palliative care which was released in 2020. This called for an additional \$275 million per year investment in palliative care to reach World Health Organisation standards and provide equal access to all terminally ill people in Queensland.¹¹

The State Government response was the election announcement last year of \$28 million per year for palliative care, which still leaves a **shortfall of \$247 million per year.**

Because of government underfunding, most terminally ill patients do not receive palliative care until the last few weeks or months of their life, and some in the regions do not have access to it at all, so how can there be a real choice for terminally ill patients 12 months out between life and death?

It should be quite possible to fix this \$247 million per annum shortfall, if the Government was inclined to do so, as it only amounts to \$1 per week for every Queenslanders. In comparison, a 3 km stretch of a new section of the Ipswich Motorway costs approx. \$400 million.

Even before the underfunding has been fixed, **the Queensland Government needs to implement a long-term educational advertising campaign educate the public about palliative care and its ability to ease the dying process in relieving pain and caring not only for patients but also for their families.**

To quote Brisbane palliative medicine specialist Dr Phillip Good in oral evidence to the previous Health Committee in 2019: “Our viewpoint is that, until you have an equitable, world class palliative care system across the state, it seems premature to introduce a pathway that some people may choose to go down when they have not had good access to good symptom control.”

In other words, do not introduce euthanasia laws in Queensland, at least while palliative care services are so patchy and hard to access. And this situation will take years to fix because of the training that needs to be done to boost the numbers of specialist doctors and nurses, as well as putting in place the necessary supporting structures.

Otherwise, the message you would be giving the public is this: Your Government will help you kill yourself, but won't provide you the care you need to relieve your suffering.

Some final points we wish to make about palliative care:

It is entirely ethical, completely legal and best medical practice for a doctor to do whatever it takes to relieve a patient's pain, even if it has the unintended but possible effect of hastening death.

In the very rare cases when physical pain cannot be managed adequately, palliative care specialists can use a form of light sedation to keep the dying patient comfortable, whether to allow a brief “time out” at peaks of pain, or to manage terminal symptoms.

¹¹

https://palliativecareqld.org.au/truechoicecampaign/?utm_source=phpList&utm_medium=email&utm_campaign=Please+make+a+short+submission...&utm_content=HTML#:~:text=PCQ%20worked%20with%20the%20sector,terminally%20ill%20people%20in%20Queensland

This is called palliative sedation, or terminal sedation because in the rare instances it is required it typically occurs in the last weeks or days of a patient's life.

We note that the euthanasia lobby tries to confuse the issue and demonize this perfectly legitimate technique by suggesting that there are no safeguards around it.

This is utter nonsense, and again is a tactic to confuse the public and muddy the waters.

There does not have to be any safeguards around a practice which only seeks to relieve a patient's pain, unlike euthanasia which needs very strict safeguards that even then will only prevent *some* wrongful deaths.

The Australian Family Association is willing to present evidence at a public hearing of the Health Committee.

Sincerely,



Michael Ord

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Queensland Vice-President

On behalf of the Queensland Branch of the Australian Family Association

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