Cherish Life Queensland's submission to the Queensland Parliament's Health and Environment Committee regarding the *Voluntary Assisted Dying Bill 2021*.

Cherish Life Queensland* is grateful to the Health Committee for the opportunity to make a submission against the "Voluntary Assisted Dying" Bill 2021 (the Bill hereafter).

Cherish Life is opposed to all forms euthanasia and assisted suicide, and therefore is opposed to the Bill. We recommend an outright rejection of it by the Queensland Parliament Health and Environment Committee.

We are deeply concerned that if enacted the legislation would lead to many extra deaths in Queensland every year. Including wrongful deaths due to suicide contagion as well as from people accessing euthanasia or assisted suicide due to error, coercion, or because of insufficient palliative care services to their area meant they felt they had no other "choice", ironically.

Our submission against the Bill seeks to:

I. suggest amendments which would make what we deem a very dangerous Bill, less dangerous, and
II. warn the Health Committee that were would be many extra deaths in Queensland every year if this Bill were to pass, and
III. present a case for enshrining in law equitable access to palliative care services, as this Bill exacerbates the current barriers and inequalities many Queenslanders face in accessing to specialist palliative care services.

While euthanasia legislation of any kind is inherently dangerous, and at odds with mainstream medical professionals and peak medical bodies such as the AMA, we note that this Bill is particularly reckless and would have devastating effects on the Queensland Health system by placing a crushingly cruel burden to be party to euthanasia on faith-affiliated health care providers.

This Bill wrongly elevates the "right" of seekers of assisted suicide and euthanasia above the "right" of doctors and faith-affiliated healthcare institutions to fully conscientiously object from being part of it.

The Bill is also intrinsically flawed as it hinges on a false pessimistic dichotomy which holds the basic view “That unless the government facilitates people being able to kill themself or be killed at the end of life, they will die in terrible pain.” This grim and frightening picture is simply not true. World-class palliative care available across Queensland is what is needed and is the real “dying with dignity”, and indeed palliative care specialists can mitigate physical suffering. Hundreds of Australian Palliative Care specialists were signatory to an open letter in 2017 which addressed fallacy that palliative care was ineffective against some pain, stating “*Current Australian data indicates that no more than 2 in every 100 Palliative Care patients would be in moderate or severe pain at the end of life. In these unusual cases where when all other methods of palliation for pain and other symptoms is inadequate, and if the patient agrees, palliative sedation therapy is available to provide adequate relief of suffering.”*[1]

*Cherish Life Queensland (formerly known as Queensland Right to Life) was established in 1970 and advocates for the right to life from conception until natural death. The “right to life” essentially means the right not to be killed. We are a passionate community comprising tens of thousands of mostly Queenslanders from a diversity of backgrounds.

[1] An open letter to Australian politicians signs by hundreds of Palliative Care Specialists in 2017, a copy is in the appendices.

PART I: SUGGESTED AMENDMENTS

AMENDMENT 1

INDIVIDUAL MEDICAL PRACTITIONERS' SHOULD BE GRANTED THE RIGHT TO A FULL CONSCIOUS OBJECTION TO EUTHANASIA AND ASSISTED SUICIDE.

Under s16(4)(2)(b) of the *Voluntary Assisted Dying Bill 2021 (Qld)*, a health practitioner who has a conscientious objection to voluntary assisted dying is still mandated to perform acts that help a patient obtain access to assisted dying. The health practitioner is expected to provide either "information about a health practitioner, health service provider or service" who, "in the practitioner's belief", is able to help the patient obtain access to assisted dying, or "the details of an official voluntary assisted dying care navigator service." This means that the doctor with a conscientious objection to euthanasia or assisted suicide is still complicit with the outcome of a patient killed, either by assisted suicide or euthanasia. This is completely unacceptable. The right to a conscientious objection is enshrined both in Queensland, Australian and international laws. Should these objections be based on religious beliefs, the right to practice these beliefs and not to be forced to participate in an action against one's faith are also firmly in place in law. The *Queensland Human Rights Act 2019* is one of these laws. The statement of compatibility accompanying the Bill fails to adequately weigh the right of a doctor to have a full conscientious objection to euthanasia and assisted suicide, against the seemingly competing "right" of a patient seeking assisted suicide or euthanasia.

A full conscientious objection is required, meaning the right to not provide information on it, the right not to have to perform euthanasia or prescribe poison and the right not to refer patients to doctor who performs euthanasia or facilitates assisted suicide.
It's clear the Bill holds someone's "right" to access euthanasia or assisted suicide as the highest "right" which is unfair and unbalanced.

If the purpose of this overreaching provision is to ensure that everyone who seeks access to assisted dying will receive it, the provision goes beyond what is necessary to achieve that purpose. For instance, information about official voluntary assisted dying care navigator services can be made readily available on the Queensland Health website.

Moreover, this clause is in direct conflict with s84(1), which states that "a registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to (a) provide information to another person about voluntary assisted dying". s84(2) reiterates the contradictory obligation to provide information on alternative practitioners or services who can provide assisted dying.

s85 similarly compels speech pathologists to "inform the employer or other person of another speech pathologist or speech pathology service who, in the speech pathologist's belief, is likely to be able to assist in providing the speech pathology services requested" in relation to voluntary assisted dying.

This is forced proximate material co-operation in what the practitioner deems wrong (whether based on bioethical, medical, religious, moral or other beliefs) and harmful to the patient.

Professor David Albert Jones of the Anscombe Bioethics Centre at Oxford comments on the issue:

"In the first place it utterly fails to establish the duty of doctors to object to practices and procedures that are unconscionable and harmful, discriminatory, unjust or unethical. The right to conscientious objection is based on the duty to be conscientious which is fundamental to medical ethics. In the second place, 'conscientious objection' is presented as conflicting with 'patient care'. This overlooks the fact that there can be no adequate patient care without conscientious healthcare professionals.… if a doctor objects in conscience to participation in torture or capital punishment or to force feeding of a prisoner who is on hunger strike, it would be unprincipled for them to find someone with fewer scruples to do the deed for them. To require a conscientious objector to facilitate delivery of the procedure to which they object is a direct attack on person's conscience and moral integrity, and thus a serious harm to them. It would be much better to say nothing about conscientious objection than to undermine it by imposing a requirement for 'effective and timely referral'."[2]

Dr Bernadette Flood explains:

"Conscientious objection is a right derived from the right to freedom of thought, conscience and religion, as set out in the Universal Declaration of Human Rights. The right to conscientious objection is not a right per se since international instruments of the United Nations do not make direct reference to such a right, but rather is normally characterised as a derivative right; a right that is derived from an interpretation of the right to freedom of thought, conscience and religion."[3]

The European Centre for Law and Justice states:

"Conscience is proper to human beings and the source of justice. Article 1 of the Universal Declaration of Human Rights defines human beings as 'endowed with reason and conscience'. The universality of conscience is the source of universality of justice and human rights."[4]

Dr Clair de La Hougue, fellow of the European Centre for Law and Justice, elucidates:

"As human beings are endowed with conscience and able to make a moral judgement. Conscientious objection is both a duty, enshrined in Principle IV of the Nuremberg Principles, and a right. This is why it was already mentioned in the Convention and the Covenant. The development of international human rights law has led to recognise

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2 Michael Cook, "World Medical Association moots mandatory referral for abortion and euthanasia", *BioEdge*, 30 May 2021 <https://www.bioedge.org/bioethics/world-medical-association-moots-mandatory-referral-for-abortion-and-euthanasia/13817>.

3 Bernadette Flood PhD M.P.S.I., "Assisted Suicide and Euthanasia: pharmacists must also have the right to conscientious objection", *Life Institute* <https://thelifeinstitute net/blog/2021/assisted-suicide-and-euthanasia-pharmacists-must-also-have-the-right-to-conscientious-objection>.

4 "The right to conscientious objection of medical practitioners", *United Nations Human Rights Council*, Session 31, Geneva, 8 March 2016 <https://www.fiamc.org/bioethics/conscientious-objection/the-right-to-conscientious-objection-of-medical-practitioners/>.

objection as an integral part of freedom of conscience."[5]

In General Comment 22 (1993) on Article 18, the Human Rights Committee (HRC) stated that "The Covenant does not explicitly refer to a right to conscientious objection, but the Committee believes that such a right can be derived from article 18, inasmuch as the obligation to use lethal force may seriously conflict with the freedom of conscience and the right to manifest one's religion or belief."[6]

A law which disallows a doctor's conscientious objection is likely to deter the most conscientious young people from becoming doctors. Would this be in the public interest? The Hippocratic Oath states: "I will give no deadly medicine to anyone if asked, nor suggest any such counsel..." Forcing a medical practitioner to advise a patient on how to access voluntary assisted dying flies in the face of basic medical ethics.

Frank Brennan observes:

"Australia is a signatory to the International Covenant on Civil and Political Rights. The terms of that Covenant provide a convenient benchmark for most individuals and groups who espouse human rights. The freedom of conscience and religion is one of the few non-derogable rights in the Covenant. This means that a signatory may not interfere with the exercise of the right even during a national emergency — whereas other rights in the Covenant can be cut back during times of public emergency which threatens the life of the nation — but only to the extent strictly required by the exigencies of the situation and provided that that cut back applies in a non-discriminatory way to all persons."[7]

The weak and contradictory provisions for conscientious objection in the *Voluntary Assisted Dying Bill 2021 (Qld)* do not uphold Australia's international obligations.

In addition, under the *Fair Work Act 2009 (Cth)*, employees are to be protected from coercion (s343) and undue influence or pressure (s344). When the legislature forces medical practitioners to participate materially in acts against their conscience, that nullifies laws designed to protect them at work.

Additionally the Queensland *Human Rights Act 2019* enshrines in law the right to religious beliefs and to carry out those beliefs (if some doctors' conscientious objections rest on their religious beliefs).

Other Australian jurisdictions have better protections for individual doctors that this Bill proposes.

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5 Dr Clair de La Hougue, "The right to conscientious objection of medical practitioners", *United Nations Human Rights Council*, Session 31, Geneva, 8 March 2016 <http://9afb0ee4c2ca3737b892-e804076442d956681ee1e5a58d07b27b r59.cf2 rackcdn.com/ECLJ%20Docs/The%20right%20to%20conscientious%20objection%20of%20medical%20practitioners%2C%20Dr%20Claire%20de%20La%20Hougue.pdf>.

6 *Ibid.*

7 Frank Brennan, "Euthanasia: doctors' conscience vs patient rights", *Eureka Street*, 2 March 2009 <https://www.eurekastreet.com.au/article/euthanasia—doctors--conscience-vs-patient-rights>.

VIC: "Written into the law is a strong protection for health professionals who have a conscientious objection to euthanasia.[8]They can refuse to be involved in any aspect of the process — including prescribing the medication, providing information or being present when the drug is taken.

Health professionals are also under no obligation to refer a patient to a doctor who is willing to participate."

WA: "Health practitioners are also able to refuse to participate in voluntary assisted dying for any reason (including conscientious objection)[9]. Health care workers must not initiate discussion about, or suggest, voluntary assisted dying to a person to whom they are providing health or professional care services. The exception to this is for medical practitioners or nurse practitioners if, at the same time, they also inform the person about treatment and palliative care options available to them and the likely outcomes of that care and treatment."

Likely affects if enacted

The Health Committee also needs to look at the likely effects of such legislation if enacted:

- It's likely it would lead to employment and workplace discrimination against those with objections to euthanasia and assisted suicide, whether they be founded on religious beliefs or otherwise.
- This could also pass onto discrimination in university placements for hopeful medical students.
- Regional and rural areas may witness even less doctors putting up their hand to service those areas, for fear they will be called upon to be party to euthanasia and assisted suicide.
- Some doctors may also prefer to leave the profession rather than be complicit in killing a patient, as some have already indicated. This would lead to further under resourcing of the Queensland Health System, the pinch of which would probably be felt in already suffering regional areas.
- Some doctors many choose not to treat geratic or terminally ill patients for fear they may be asked about assisted suicide or euthanasia.

The question also must be asked: given the fact that the Australian Medical Association* and the vast majority of oncologists and palliative care specialists (who do the lion's share of end of life care) are opposed to euthanasia and assisted suicide – what right does the Queensland government have to force doctors to be complicit in it? Why aren't the parliamentarians listening to the doctors and medical fraternity? It's not the politicians sitting in parliament who will have to do the killing, it is the doctors who have trained for decades to save life.

The lack of a full conscientious objection in the Bill in its current state is both brutal and

[8] https://www.abc.net.au/news/2018-11-09/euthanasia-assisted-dying-in-victoria-enabling-choice-for-dying/10478420
[9] https://ww2.health.wa.gov.au/voluntaryassisteddying

unfair, it needs to be amended to grant doctors a full conscientious right.

*The Australian Medical Association's position statement on euthanasia and assisted suicide states: "The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life."[10]

Similarly 107 out of 109 of the world's national medical bodies are opposed to euthanasia and assisted suicide.

AMENDMENT 2

INSTITUTIONS BE GIVEN THE RIGHT OF A FULL INSTITUTIONAL CONSCIENTIOUS OBJECTION.

Under s90(2) institutions whose charter is opposed to euthanasia (i.e. Catholic Health Australia, UnitingCare, BaptistCare, Anglicare as well as many others) would be forced to supply patients with information on euthanasia or assisted suicide, and allow euthanasia and assisted suicide doctors and "an official voluntary assisted dying care navigator service" on to the premises. In the case where the patient is a permanent resident of a facility, like an aged care home for example, the institution would be forced to let the assisted suicide or euthanasia take place on the premisess by an outside doctor coming in to kill the patient or the poison being delivered to the facility. This is outrageous to say the least.

Once again, the "balance of rights" is wildly out of kilter, strongly favouring the "right "of individuals seeking euthanasia and assisted suicide over the right of these institutions to abide by their charter, as well as the rights of thousands of individuals who work in these faith-affiliated established places of healing and care.

Queensland's lack of conscientious objection for institutions is extreme, discriminatory and out of step with other Australian jurisdictions.

The SA law explicitly allows hospitals the right to refuse to authorise or permit "any part" of the VAD process. The identical provisions should be enshrined in this Queensland Bill.

It could be argued that this extreme legislation is in breach of right to freedom of thought, conscience and religious obligations. Australia is a party to seven key human rights treaties. The most relevant obligations when discussing voluntary euthanasia are contained in the *International Covenant on Civil and Political Rights* (ICCPR).[204] The following rights in the ICCPR may be engaged by the practice of voluntary euthanasia[11]:

[10] AMA's position statement on Euthanasia, 2016, https://www.ama.com.au/position-statement/euthanasia-and-physician-assisted-suicide-2016

[11] ICCPR number 204, which Australia is party to, can be found here: https://humanrights.gov.au/our-work/age-discrimination/publications/euthanasia-human-rights-and-law

- right to life (article 6)
- freedom from cruel, inhumane or degrading treatment (article 7)
- right to respect for private life (article 17)
- freedom of thought, conscience, and religion (article 18).

It could also be argued that the "right" of residents of a Catholic or other Christian nursing home to choose a place of residence in accordance with their faith, is being flouted or even trampled on. For example, a Catholic resident wouldn't want the resident (and presumably friend) in the next room being killed one day by a 'VAD' doctor coming on premises with a lethal needle. It would be deeply distressing for all the other residents and staff to say the least. Where are the other residents' rights in this scenario? A right to peacefully live in a place that advertises it shares that faith? Once again a strong, unfair and arguably unlawful bias towards the "right" of the euthanasia seeker.

Likely effects if enacted

If institutions aren't allowed to operate within their theological or ethical charter by having a complete institutional conscientious objection to euthanasia or assisted suicide, this would undoubtedly be viewed be an impediment to their continuing care of the dying. All of these health care providers are not-for-profits and some run at a loss in a humane bid to make sure no one is without care. These institutions are life-centric - having to be complicit with a patient being killed may be the last straw for some of them. Such an iron-fisted lack of respect for their values may lead to a number of them closing hospitals, hospices and aged care facilities. This very real possibly was raised at the Queensland Health Committee End-of-Life-Inquiry on 4 July 2019 with the head of Southern Cross Care stating: "If PAS [physician assisted dying] legislation becomes mandatory or there are inadequate provisions for conscientious objection then, rather than compromise their ethical standards, many aged care providers, particularly those from a Judeo-Christian religious tradition, may exit the industry."[12]

Will we eventually see such entities lose not-for-profit status in an attempt to punish them for abiding by their ethical standards? This was the fate faced by a small hospice in British Columbia, the Irene Thomas Hospice.[13]

Will there be intentional set-ups and lawsuits against faith-based health care institutions and individuals who refuse to be complicit with euthanasia and assisted suicide?

A number in our community are in retirement villages or nursing homes run by faith-based groups. One of the reasons they chose those facilities was because they were aligned with their Christian values, a faith which 56% of Queenslanders share according

[12] Queensland Parliament Health Committee, End of Life Enquiry interview of witnesses, 9 July 2019

[13] Xavier Symons, "Canadian hospice could be defunded because it opposes euthanasia", *BioEdge*, 18 January 2020 <https://www.bioedge.org/bioethics/b.c.-hospice-could-lose-funding-over-maid-stance/13290>.

to the 2016 Census[14]. The thought that an outsider is able to come in, on to the premisess and help kill a fellow resident, is both distressing and frightening.
Questions:
Why does the right of a relative few right trump the collective right of many to exercise their conscience as a group? Why can't the few go to a premises with a similar world view. Why the elevation of the "right to die" above every other right in Queensland?

Why isn't the state government pursuing a better deal for faith-based health care providers should this Bill pass? Catholic Health Australia, for example provides one bed in five in Queensland, and along with Christian providers, fills many of the state government's gaps when it comes to hospitals, aged care and hospices. Organisations like Catholic Health Australia, BaptistCare, UnitingCare, Anglicare and others are the state government's best friends in health, so why the massive stab in the back?

The Bill must be amended so health institutions of faith have the right to a full institutional conscientious objection to euthanasia and assisted suicide.

AMENDMENT 3

THE PATIENT TO BE SEEN BY A SPECIALIST, AT LEAST ONCE, FOR FREE IN THE AREA OF THE PATIENT'S ASSUMED ILLNESS (EG AN ONCOLOGIST FOR A SUSPECTED CANCER PATIENT)

The Bill has no requirement for a patient to be seen by a specialist. This is particularly remiss; there's no doubt it would cause wrongful deaths, particularly those from disadvantaged backgrounds, and here's why.

The fact there is no requirement to be seen by a specialist was queried by Health Committee member Ali King MP at a public hearing on Monday 14 June, and the representative from Queensland Health Department conceded – that was correct there was no requirement in the legislation for a patient to be seen by a specialist.

This presents a problem from many angles:

1. In practice this could mean the doctor giving the 12 month prognosis is a newly graduated general practitioner (GP) with little or no specialised training in the person's area of suffering. This is a major red light. Incorrect diagnoses happen at a rate of 10 to 15 per cent[15]. Wrong prognosis are also not uncommon, "predicting

[14] Australian Bureau of Statistics, Census 2016 data, https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Religion%20Data%20Summary~70
[15] According to Dr Stephen Best, NZ Medical Association President, recorded on 14 September, 2015 at https://www.stuff.co.nz/national/politics/84252580/euthanasia-too-final-when-the-risk-of-error-is-to-great--doctors

prognosis and the timing of dying can be difficult"[16] a study on the accuracy of prognosis revealing: "Of the 2700 predictions, 1226 (45%) were off by more than 6 months and 488 (18%) were off by more than 12 months."[17] While a 2000 study in the British Medical Journal found that 80 per cent of prognoses for terminally ill patients were incorrect[18]. Coupled together with the additional errors that can arise because of the relative inexperience of a newly graduated GP, as opposed to a specialist of 30 years, the total error rate by receiving a diagnosis and prognosis from an inexperienced GP, for example, could be as high as 50 per cent. This huge chance for a deadly error is enough to warrant the government funding what is deemed a terminally ill patient for a specialist assessment.

2. Without seeing a specialist in the area of a patient's suffering they may miss out on the latest and best treatment for that particular condition, which in some instances may actually save their life.

3. Economic barriers to seeing a specialist. Specialists don't bulk bill, unless a patient is seeing one at a public hospital in a critical care type scenario. The Bill as it stands favours those with medium to high-cash flows who can afford to see a specialist. Put another way, the poor and unemployed would in many cases receive a substandard level of medical care under this Bill. They would also be more likely to suffer a wrongful death, because they haven't seen a specialist in the area of their suffering, for reasons explained in point 1.

4. Geographic barriers to seeing a specialist. While we acknowledge that Queensland Health did say one of the reasons they didn't stipulate that a specialist must be seen is because of the barrier this would present to regional Queenslanders accessing VAD, they seem to be tone deaf to what they are actually saying, in essence: "Hey regional Queenslanders, we will help you kill yourselves, but we can't be bothered with getting a specialist to properly assess you." Once again this is discrimination and a strong bias towards elevating euthanasia and assisted suicide above real health care which actually saves lives. Such a strong bias could also mean more people in regional Queensland are casualties of wrongful deaths if this Bill were to pass.

Additionally:

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[16] Excerpt from Australian Government "Consensus Statement: essential elements for safe and high-quality end-of-life care, 2015", https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Consensus-Statement-Essential-Elements-forsafe-high-quality-end-of-life-care.pdf

[17] A UK study on the prognostic accuracy for brain cancer, recorded in https://pubmed.ncbi.nlm.nih.gov/24160479/

[18] Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study, British Medical Journal, https://www.bmj.com/content/bmj/320/7233/469.full.pdf

Section 21 (2) is dangerously ambiguous. If the co-ordinating practitioner is unsure about the diagnosis / prognosis or the decision-making capacity, the section says the coordinating practitioner must refer the person to a registered *"health practitioner who has appropriate skill and training to determine the matter"*. This does not even not insist on a specialist.

An amendment should be: it can only be a specialist doctor, or a team of specialist doctors who can give a prognosis on which the "access to VAD" hinges. The specialist should ideally be in the area of the patient's suffering, ie an oncologist for a cancer patient. But despite the specialists' involvement, the legislation should ensure they have the right to a full conscientious objection to assisted suicide or euthanasia (meaning they don't have to provide on it nor refer for it or be part of it in any way).

AMENDMENT 4

PATIENT TO BE ASSESSED BY A PALLIATIVE CARE SPECIALIST (FOR FREE).

The right for anyone who is suspected of having a terminal illness to be seen and treated by a palliative care specialist, for free, from the point of terminal diagnosis should be written into this Bill.

Please see Section III for more details on this and the dire need for greater investment in palliative care in Queensland.

AMENDMENT 5

A REQUIREMENT TO BE ASSESSED BY A PSYCHIATRIST PRIOR TO ACCESSING EUTHANASIA AND ASSISTED SUICIDE.

Depression due to illness and feelings of hopefulness are often key drivers of requests for euthanasia and assisted suicide, data from overseas shows.

A psychiatric assessment would be able to screen for people who are depressed or acting out of character, and then help them with their mental health. Such a provision would also help reduce the number of wrongful deaths due to underlying mental health illness or mental health disruptions, as well as suicide contagion that often accompanies legalising of euthanasia of any kind.

AMENDMENT 6

A SIX-MONTH PROGNOSIS TO ACCESS VAD INSTEAD OF A TWELVE MONTH PROGNOSIS.

Reducing the prognosis period to six months is in keeping with the euthanasia and assisted suicide legislation in Victoria, WA, Tasmania and South Australia. Shortening the access period would reduce the likelihood of wrongful death due to a wrong diagnosis or wrong prognosis (as explained in suggested amendment 3). It also allows more time for the patient to be treated by a palliative care specialist and to make sure they have also been treated by a specialist in the area of their illness.

AMENDMENT 7

CAPPING THE NUMBER OF PATIENTS, A DOCTOR CAN APPROVE OR SECOND FOR 'VAD'.

That no one medical doctor can be the co-ordinating doctor or the second approving doctor for more than five (5) patients accessing euthanasia or assisted suicide in any 12 month period.

This will mean no one doctor can make their primary occupation managing or seconding assisted suicide or euthanasia cases, as it should never be the primary intention of a doctor to take the life of their patient.

There is also the added risk that if a doctor routinely manages and / or approves euthanasia and assisted suicides there is a loss of sensitivity to the fact they are helping to kill someone.

AMENDMENT 8

BILL NAME CHANGE TO: *Euthanasia and Assisted Suicide Bill 2021* or *Medical Killing Exemption Bill 2021.*

The current Bill's name is deceptive "Voluntary assisted dying" makes it sounds like some sort of palliative care when it is actually intentional killing either by a doctor facilitating the suicide of someone through a poison cocktail or directly by via a lethal injection or drip. The Bill's name should be changed to *Euthanasia and Assisted Suicide Bill 2021 or Medical Killing Exemption Bill 2021* to accurately reflect the intention of the Bill.

AMENDMENT 9

A DOCTOR CAN NOT RAISE 'VAD' WITH A PATIENT.

A doctor raising euthanasia or assisted suicide with a patient at the end of life has obvious risks as the patient would no doubt be feeling vulnerable, scared and quite possibly physically unwell due to their illness. Arguably the doctor even raising euthanasia or assisted suicide with a terminally ill patient could be a form of subtle coercion, once again there is a strong bias towards euthanasia and assisted underpinning this legislation. Many hold doctors' opinions in high regard (if only the Queensland Government did, we wouldn't even be debating this outrageously dangerous Bill!) - a doctor with a leaning towards euthanasia or assisted suicide which becomes apparent in a consultation with a patient, may push a patient that way (even if unintended).

Allowing doctors to raise it is also out of step with euthanasia and assisted suicide laws in other parts of Australia, it is a dangerous and should be taken out of the legislation.

AMENDMENT 10

DEATH CERTIFICATES FOR 'VAD' VICTIMS MUST RECORD EITHER ASSISTED SUICIDE OR EUTHANASIA AS THE CAUSE OF DEATH.

It's unacceptable that death certificates would be falsified by recording the diagnosis of the patient rather than euthanasia or assisted suicide. This again attests to the fact this Government it trying to implement a regime where someone accessing euthanasia is the "highest right" and every other "right" and truth itself shall humbly bow. But lying is never acceptable, and when it is used to cover forms of killing it seems even more repugnant.

Such legislation also gives too much power to the VAD Board responsible for reporting VAD deaths. The euthanasia or assisted death of each Queenslander accessing "VAD" should be given to the State Coroners office and not a government appointed committee essentially appointed to regulate a lie.

AMENDMENT 11

NO 'TELE-DEATHS' ALLOWED. CARRIAGE SERVICES SUCH AS THE INTERNET AND PHONE LINES SHOULD NOT BE USED TO FACILITATE ASSISTED SUICIDE OR EUTHANASIA.

It's deeply concerning that the Queensland Government wants to use carriage services, the internet and phone system, to facilitate what is most accurately described as "tele-suicides". It's also tragically ironic that very little has been done by Queensland Health to utilise carriage services for life-saving medical appointments with specialists to Queenslanders in regional and remote areas.

AMENDMENT 12

NURSES CAN NOT ADMINISTER 'VAD'

Nurses haven't had the training of doctors. Sometimes euthanasia can go terribly wrong, here are just a few cases;

Dr Pieter Admiraal, who practised euthanasia in the Netherlands for years, warned in 1995 that "every doctor who decides to assist in suicide must be aware that something can go wrong, with the result being a failure of the suicide. For this reason, one should always be prepared to proceed to active euthanasia. In other words, the doctor should always have at hand thiopental and muscle relaxant" (to administer in the form of a lethal injection).[19]

Barbiturates are the most common substances used for assisted suicide in Oregon and in the Netherlands. Overdoses of barbiturates are known to cause distress:

- extreme gasping and muscle spasms can occur
- while losing consciousness, a person can vomit and then inhale the vomit
- panic, feelings of terror and assaultive behaviour take place from the drug-induced confusion

Other problems can include difficulty in taking the drugs, failure of the drugs to induce unconsciousness and a number of days elapsing before death occurs.[20]

In one harrowing case, a lethal prescription was delivered via courier from Oregon Health Science University to Patrick Matheny; when he tried taking the drugs four months later, he failed to die in three attempts; he started vomiting and became agitated. Finally, his brother-in-law Joe Hayes said, "I had to help him die." The body was cremated within 24 hours, so a coroner's report could not be produced, and it is uncertain whether Mr Hayes ended up smothering Mr Matheny or giving him a lethal injection, both of which are illegal in Oregon.[21] Another man revived three days after taking a lethal prescription.[22]

In another case – described by pro-euthanasia attorney Cynthia Barrett while speaking at Portland Community College – a man in Portland, Oregon had a gruesome physical reaction to the lethal dose and his wife rang 911 as it was so alarming; he was resuscitated

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19 Admiraal, P.V., "Toepassing van euthanatica", *Ned Tijdschr Geneeskd*, 2 November 1995, p. 267, via "Complications with Assisted Suicide", *Life* <http://www.life.org.nz/euthanasia/euthanasiakeyissues/complications-and-euthanasia/>.

20 *The New England Journal of Medicine (NEJM)* Volume 342:551-556, 24 February 2000 Number 8, via "Complications with Assisted Suicide", *Life* <http://www.life.org.nz/euthanasia/euthanasiakeyissues/complications-and-euthanasia/>

21 Erin Hoover, "Dilemma of assisted suicide: When?", *Oregonian*, Jan. 17,1999; Erin Hoover, "Man with ALS makes up his mind to die", *Oregonian*, March 11, 1999 – via "Ten Years of Assisted Suicide in Oregon", Patients Rights Council <http://www.patientsrightscouncil.org/site/oregon-ten-years/>.

Dr Greg Hamilton, Q954, House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill *Volume II: Evidence*, April 2005 <https://publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf>.

22 Nicolas Steenhout, "Botched executions and euthanasia", *MercatorNet*, 4 May 2014 <https://www.mercatornet.com/careful/view/botched_executions_and_euthanasia/14008>.

in hospital and later died of other causes.[23] Euthanasia may promise to be a painless process, but it can compound the trauma of a family already suffering through illness.

In Oregon, there have been 20 reports of complications (19 instances of vomiting and one patient who did not die); the actual number is unknown because over the course of 10 years, the doctors who prescribed lethal medication were present at only 21.7% of reported deaths.[24] Dr Gregory Hamilton informed the House of Lords that the complication rate is 15-20%;[25] elsewhere it is reported that ineffective suicide attempts may comprise up to 25% of cases.[26]

Another point of consideration is like a lot of doctors, many nurses do not want anything to do with euthanasia or assisted suicide. The Nurses' Professional Association of Queensland (NPAQ) has come out strongly opposing this legislation, Margaret Gilbert, the president of the NPAQ recently stating in an opinion editorial published in the Courier-Mail: "The role of nurses is, irrefutably, to help preserve life, not destroy it. We take an oath like the doctor's Hippocratic Oath not to cause harm. That is the main reason why the Nurses' Professional Association of Queensland opposes the State Government move to legalise euthanasia. The NPAQ fears the state government views assisted suicide as the easy way out because it has failed lamentably to fund palliative care. To put it bluntly, assisted suicide is cheaper."[27]

AMENDMENT 13

NO PENALTY (LEAST OF ALL 7 YEARS JAIL) FOR TRYING TO TALK SOMEONE OUT OF 'VAD'.

Within reason, a loved-one should be able to help someone considering assisted suicide or euthanasia consider their ways. This includes a robust but respectful discussion if someone wants to access "VAD" and it is of a concern to a loved-one. Such discussions

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23 Audio tape on file with author of "Ten Years of Assisted Suicide in Oregon", *Patients Rights Council* <http://www.patientsrightscouncil.org/site/oregon-ten-years/>. Also see: David Reinhard, "The pills don't kill: The case, First of two parts," *Oregonian*, March 23, 2000 and David Reinhard, "The pills don't kill: The cover-up, Second of two parts," *Oregonian*, March 26, 2000; Dr Greg Hamilton, Q957, House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill *Volume II: Evidence*, April 2005 <https://publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf>.

24 DHS, "Tenth Annual Report on Oregon's Death with Dignity Act," March 18, 2008, Table I. The annual report states that the presence of the attending physician in the 63 out of 292 reported deaths is 29%, however the calculation is mathematically inaccurate. The correct calculation is 21.5% – via "Ten Years of Assisted Suicide in Oregon", *Patients Rights Council* <http://www.patientsrightscouncil.org/site/oregon-ten-years/>.

25 Dr Greg Hamilton, Q955, House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill *Volume II: Evidence*, April 2005 <https://publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf>.

26 Ezekiel J. Emanuel, Elisabeth R. Daniels, Diane L. Fairclough, et. al, "The Practice of Euthanasia and Physician-Assisted Suicide in the United States: Adherence to Proposed Safeguards and Effects on Physicians", *Journal of the American Medical Association*, Vol. 280, No. 6, August 12,1998, p. 512; and Derek Humphrey, "Letter to the Editor", *New York Times*, December 3, 1994.

Via "Some Oregon and Washington State Assisted Suicide Abuses and Complications", *Disability Rights and Defense Fund* <https://dredf.org/public-policy/assisted-suicide/some-oregon-assisted-suicide-abuses-and-complications/>.

27 "Support palliative care not euthanasia" Margaret Gilbert, 23 March, 2021, The Courier-Mail https://www.couriermail.com.au/news/opinion/support-palliative-care-not-euthanasia/news-story/abe75e5103d10b5451f7bbca76a9a386

are not unique in close relationships at key life junctions. Discourse cannot be censored simply because it is a topic the Queensland Government obviously feels protective about.

Other instances where a robust discussion may occur because of a big potentially life-altering decision, is if someone is considering a divorce or moving interstate. There are no laws to protect this sometimes-animated discourse between loved-ones, so why the heavy-handed approach to assisted suicide and euthanasia discussions? It's absurd, and once again an overreach of this Bill.

In addition, the vast majority of evidence points to a level of coercion to get euthanasia or assisted suicide. Not the other way around. There's no argument from us that very strong laws need to exist to help to prevent people being coerced into euthanasia or assisted should this Bill pass, but loved ones should be able to encourage people to choose life in a loving way - particularly as this legislation in its current format is tipped so in favour of assisted suicide and euthanasia.

It's likely that coercion will be rife, even subtle, if this legislation passes. It's literally of grave concern. The so-called "right to die" will be perceived as a "duty to die" by those who feel like they are a burden on their families because of their illness, or perhaps a loss of bodily autonomy or even age. Many elderly people in nursing homes are lonely and already feel like "burdens" to their families. Indeed, one former (retired) palliative care specialist Dr Judith McEniery remarked in 2019, that "loneliness is the new cancer."

Elder abuse is already a well-documented problem in Queensland, so how much worse will it be if this legislation were to pass. The Queensland Government should at least afford families and other loved ones the right to try to talk nanna out of choosing assisted suicide or euthanasia because "she only has a little while to live and feels like a nuisance."

Proponents of euthanasia also concede that there will be wrongful deaths of the elderly due to coercion and even bullying. British euthanasia activist Dr Henry Marsh once infamously quipped: "Even if a few grannies get bullied into [suicide], isn't that the price worth paying for all the people who could die with dignity?"[28]

Additionally this legislation sends a very dangerous signal to Queenslanders that life isn't valuable if it is less than perfect because of illness, age or a disability or perhaps even circumstance. When does it stop? In Belgium and The Netherlands the euthanasia and assisted suicide slippery slope is well underway – with children and depressed people accessing medically assisted killing.

At least the government can give families the right to protest a death-centric decision, respectfully of course.The silencing of dissenting voices in this legislation and the elevation of the "right" to euthanasia and assisted suicide is shocking.

[28] Dr Henry Marsh, quoted in Medscape https://www.medscape.com/viewarticle/879187

PART II: *ANALYSIS*: WHY LEGALISING ASSISTED SUICIDE & EUTHANASIA WILL LEAD TO MORE DEATHS EACH YEAR IN QUEENSLAND

Summary – ***Empirical evidence from jurisdictions that have legalised euthanasia and/or assisted suicide, such as Victoria, the Netherlands, Belgium, Switzerland, Canada, Oregon and Washington State, shows that the overall number and relative frequency (as a % of annual deaths/per 100,000 people) of both medically-assisted suicides, euthanasia and total suicides has increased dramatically. Overall, these regions have recorded an average increase of 55.8% in the number of total suicides committed each year. Additionally, since legalising assisted suicide/ euthanasia, the number and rate of non-assisted suicides in regions such as Victoria, the Netherlands and Oregon has increased.***

GLOBAL EVIDENCE OF EXTRA DEATHS EACH YEAR

A. European & North American Case Studies

Table 1 (below) provides a summary of the salient data from four jurisdictions—the Netherlands, Belgium, Switzerland and Canada—with some form of legalised euthanasia and assisted-suicide services. 'E & AS' figures represent the number of euthanasia (E) and assisted-suicide (AS) cases reported to the relevant reporting body for each respective country, while 'NAS' figures represent instances of non-assisted suicide. Total suicide figures represent this number + the number of non-assisted suicide cases from the corresponding year, with the aim of capturing the *overall level of suicidality* in each country.

In addition to absolute figures, statistics related to the relative frequency of E & AS cases and total suicides have been included, in order that the relative effect of each statistic can be gauged. All statistics also include a measure of growth (as a %) from the start of the period to the latest available data.

Overall, these figures illustrate a dramatic increase in almost every country for each category. For example, in the brief period since 2016 in which euthanasia and assisted suicide have been legal in Canada, authorities have recorded a *454.8% increase* in the number of medically-assisted suicides (and euthanasia) and a *421.1% increase* in the percentage of annual deaths for which these suicides account. Moreover, from 2002 to 2018, the Netherlands has experienced a *116.3% increase* in the total suicide rate, with a peak of *49.8* suicides per 100,000 people in 2017, and a last recorded value of *46.3*.

The highest recorded growth is in the overall number of euthanasia and assisted-suicide cases in Belgium, which has grown an astonishing *1029.8%*. This is followed by

Switzerland, which has recorded a *528.9% increase* in the number of cases of euthanasia and assisted suicide and a *503.4% increase* in the percentage of yearly deaths by these means. *(Please note that the full references for this section is at the back of this section.)*

	The Netherlands	Belgium	Switzerland	Canada
Legal Status	Legal since 2002	Legal since 2002*	Assisted suicide de facto legal since 1937*	Legal since 2016
# of Reported E & AS Cases				
Year of legalisation	1,882	235	187	1,015
1 year post-	1,815	349	203	2,833
5 years post-	2,120	704	253	
10 years post-	4,180	1807**	587	
Last recorded	6,126	2,655	1,176	5,631
Growth as %	***225.5%***	***1029.8%***	***528.9%***	***454.8%***
	(2002 - 2018)	*(2003 - 2019)*	*(2003 - 2018)*	*(2016 - 2019)*
% of Annual Deaths from E & AS				
Year of legalisation	1.3%		0.3%	0.4%
1 year post-	1.3%		0.3%	1.0%
5 years post-	1.6%	0.7%	0.4%	
10 years post-	3.0%	1.65%**	0.9%	
Last recorded	4.0%	2.4%	1.8%	2.0%
Growth as %	***207.7%***	***264.2%***	***503.4%***	***421.1%***
	(2002 - 2018)	*(2008- 2019)*	*(2003 - 2018)*	*(2016 - 2019)*
# of Total Suicides (E + AS + NAS)				
Year of legalisation	3,449		1,456	4,992
1 year post-	3,315		1,487	6,991
5 years post-	3,473	2,704	1,566	
10 years post-	5,933	3700**	1,657	
Last recorded	7,955	3,931	2,178	9,642
Growth as %	***130.6%***	***45.4%***	***49.6%***	***93.1%***
	(2002 - 2018)	*(2008- 2016)*	*(2003 - 2018)*	*(2016 - 2019)*
Total Suicide Rate per 100,000 (E + AS + NAS)				
Year of legalisation	21.4		19.8	13.8
1 year post-	20.5		20.1	19.1
5 years post-	21.2	22.0	20.3	
10 years post-	35.5	33.2**	20.4	
Last recorded	46.3	34.6	25.5	25.7
Growth as %	***116.4%***	***57.3%***	***28.8%***	***86.2%***
	(2002 - 2018)	*(2008- 2016)*	*(2003 - 2018)*	*(2016 - 2019)*

Table 1: European and Canadian summary statistics
Notes:
Euthanasia = 'E', Assisted-suicide = 'AS', Non-assisted suicide = 'NAS'
Suicide rates are not age-standardised and thus represent actual numbers.
Percentage/rate figures have been rounded to 1 decimal place, while growth calculations utilise actual values.
References are provided at the end of this article.
**Reliable data is unavailable for Belgium and Switzerland from the year of legalisation, so the year 2003 was used as a surrogate as this marks the beginning of the reliable data. Additional suicide data limitations regarding Belgium further affected the scope of the displayed figures.*
***Revisory research suggests that in 2013, up to 40% of all euthanasia cases in Belgium were not reported[29]. Therefore, marked figures should be considered low-end estimate*

[29] Chambaere et al. (2015)

B. Additional Jurisdictional Evidence: Australian and US States

In addition to these four nations, there are a number of states from Australia and the United States that have legalised assisted-suicide. Australians in Victoria have had legal access to assisted suicide since 2019, while Oregon, Washington State and Vermont have all had legalised assisted-suicide for more than 10 years. While reporting data in Vermont is regrettably limited, evidence from Victoria, Oregon and Washington displays a similar pattern to that found in the rest of the world.

This is displayed in Table 2 (below), which shows the total suicide rate (per 100,000 people) for all regions discussed thus far, during the year of legalisation (or the earliest available date near to legalisation) and from the last available date, along with the overall growth of these statistics (as a %). Also included is a global average for each measure which shows the global trend for nations with legalised euthanasia and/or assisted-suicide.

		Total Suicide Rate per 100,000 (E + AS + NAS)		
	Legal Status	Earliest Available (year)	Last Recorded (year)	**Growth as %**
Victoria	VAD legal since 2019 *(data from 2017-2020 for a min 3-year trend)*	10.9 *(2017)*	13.1 *(2020)*	***20.6%***
Oregon	Assisted-suicide legal since 1997*	17.9 *(1998)*	26.0 *(2019)*	***45.3%***
Washington State	Assisted-suicide legal since 2009	14.7 *(2009)*	20.0 *(2018)*	***36.0%***
The Netherlands	Legal since 2002	21.4 *(2002)*	46.3 *(2018)*	***116.4%***
Belgium	Legal since 2002	22.0 *(2008)*	34.6 *(2016)*	***57.3%***
Switzerland	Assisted-suicide de facto legal since 1937 Euthanasia still illegal	19.8 *(2003)*	25.5 *(2018)*	***28.8%***
Canada	Legal since 2016	13.8 *(2016)*	25.7 *(2019)*	***86.2%***
Global Average		*17.2*	*27.3*	***55.8%***

Table 2: Global summary statistics
Notes:
'VAD' = Voluntary Assisted Dying
Suicide rates are not age-standardised and thus represent actual numbers
Percentage/rate figures have been rounded to 1 decimal place, while growth calculations utilise actual values.
References are provided at the end of this article.
**Oregon data begins in 1998*

As noted, Victoria, Oregon and Washington State have all seen similar increases in their total suicide rate (E+AS +NAS), by *20.6%*, *45.3%* and *36%* respectively. **When viewed in sum, after legalising euthanasia and/or assisted suicide, the seven regions show an average growth of *55.8%* in the total rate of suicides performed each year.**

C. Non-assisted Suicide: Increases Following Legalised Euthanasia

The data reveals that the legalisation of E + AS in both The Netherlands and Oregon has led to an increase in non-assisted suicide rates too. This is illustrated in the table below. It shows the Netherlands and Oregon have seen increases in their respective non-assisted suicide rates: from 9.9 to 10.6 per 100,000 and from 17.4 to 21.5 per 100,000 of population.

	Non-assisted Suicide Rate per 100,000 (NAS)	
	Year of legalisation (year)	Last Recorded (year)
The Netherlands	9.9 *(2002)*	10.6 *(2018)*
Oregon*	17.4 *(1998)*	21.5 *(2019)*

Table 3: The Netherlands and Oregon non-assisted suicide rates since legalisation
Notes:
Suicide rates are not age-standardised and thus represent actual numbers
References are provided at the end of this article.
**Oregon data begins in 1998*

In Victoria the non-assisted suicide rate has not decreased by about 50 people per year, following 'VAD' being legalised, as the Health Minister Jill Hennessy said would happen at the time of the debate in 2017[30]. But rather has rather it has increased by 4 people. In 2017 the number of Victorians who suicided was 694, and in the first 12 months the legislation was in operation the number of Victorians who suicided (non-assisted) was 698.

QUEENSLAND'S LIKELY INCREASE IN OVERALL SUICIDES IF ASSISTED SUICIDE & EUTHANASIA IS LEGALISED

Empirical evidence indicates that Queensland may see an increase in the rate of non-assisted suicides committed each year due to a suicide contagion effect, and it's highly likely there will a marked increase in the total rate of suicidality (E+AS + NAS) every year.

[30] Jill Hennessey's claim, reported by the Australian Care Alliance, https://d3n8a8pro7vhmx.cloudfront.net/australiancarealliance/pages/64/attachments/original/1624935082/Social_contagion_of_suicide.pdf?1624935082

Utilising Queensland's latest available suicide data and the global average increase in total suicide rates from the seven examined jurisdictions (55.8% over an average timeframe of approximately 11 years), Figure 1 (below) illustrates the projected path of Queensland's total suicide rate (E+AS +NAS), should euthanasia be legalised. This is a very sad projection, and for the sake of lives, this legislation must be rejected.

A projection of overall suicide rates should assisted suicide and euthanasia be legalised can be is shown below.

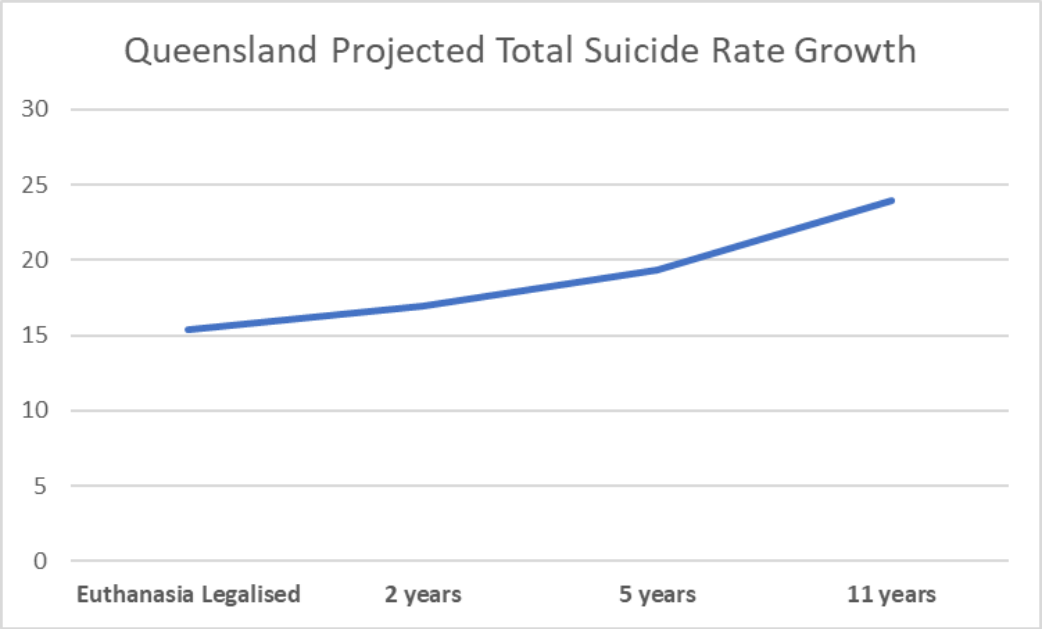

Figure 1: Queensland Projected Total Suicide Rate Growth (per 100,000 of population)

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SECTION III: THE NEED FOR EQUITABLE PALLIATIVE CARE INVESTMENT IN QUEENSLAND

The President of the Queensland chapter of the Australian Medical Association, Professor Chris Perry, recently said of the states' palliative care services: "While palliative care should be available from diagnosis of a life-limiting illness, unfortunately the lack of funding means that specialist palliative care services may only be available to those with a prognosis of less than three months." [31]

Yet under the current Bill someone can access "VAD" with a 12 month prognosis. There lies a major dangerous disparity between a terminally ill Queenslander being able to access assisted suicide and euthanasia nine months before they can access palliative care. This inequality could indeed lead to wrongful deaths as these people choose assisted suicide or euthanasia as they really feel they have no other "choice", ironically.

By Queensland Health's own admission very few people understand palliative care and what's available. Their website states "Palliative care is increasingly a topic of discussion and concern for Queenslanders, but not everyone knows what it is or when it would be accessed." [32]

According to Palliative Care Queensland, palliative care is underfunded by $275 million per year, the deficit being most experienced in regional Queensland, with some areas like Rockhampton having no palliative care specialist at all. The current state government commitment of an extra $28.5 million for 6 years is only a fraction of what is needed.

For decades different policy reforms and budgets have failed to properly address the palliative care deficit and ensure equitable and timely access to this essential and humane end-of-life specialty care for all Queenslanders. It's time that there is legislation to ensure that all Queenslanders have the right access to timely palliative care specialist services, for free, should they need it.

As such would like to see the introduction of a *Palliative Care Equitable Access Bill 2021* or something similar and the rejection of the *Voluntary Assisted Dying Bill.* Or if tragically the "VAD" Bill is passed, that complementary palliative care legislation is enacted that ensures sufficient and free access to palliative care for all Queenslanders.

[31] "Patients spend less than one week in palliative care hospital stays", 26 May 201, The Courier-Mail, https://www.couriermail.com.au/news/queensland/qld-politics/patients-spend-less-than-one-week-in-palliative-care-hospital-stays/news-story/005e887c2f2cfdf02af2f9090b78a86b

[32] Queensland health website, "What is Palliative Care" https://www.health.qld.gov.au/news-events/news/what-is-palliative-care-Queensland

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An Open Letter to the Members of Parliament by Australian Palliative Care Professionals

We, the undersigned Australian Palliative Medicine professionals, do not support the introduction of medically assisted suicide or euthanasia in the states of Victoria and New South Wales. We are also writing to address claims made about Palliative Care by assisted suicide advocates, including Mr Andrew Denton, to the public and in the media. We do not intend this response as an attack on Mr Denton, and wish him well with a good recovery in his present illness.

We work every day with people who are seriously ill and dying, to support them and their families and carers when burdened by their illness or condition, and in their time of need.

Although the standard of Australian Palliative Care services, whether in the home or in the medical setting, are currently rated second in the world, this is not widely known in our community, and these services and our care are not well understood.

Our work is a good news story that should provide the public with great confidence.

Instead, in the current debates on euthanasia and assisted suicide, we frequently observe that public confidence in Palliative Care is being actively and deliberately undermined. Assertions include that Palliative Care doctors either cannot or will not relieve suffering and that assisted suicide, and in some cases euthanasia, is needed to address this.

This is simply false.

Current Australian data indicates that no more than 2 in every 100 Palliative Care patients would be in moderate or severe pain at the end of life. In these unusual cases where when all other methods of palliation for pain and other symptoms is inadequate, and if the patient agrees, palliative sedation therapy is available to provide adequate relief of suffering.

This is not just a ‘pharmacological oblivion’ as some have claimed. It is the careful management of pain and other severe symptoms through individualised medication plans at therapeutically recognised doses, and with dignified personal care, delivered by experienced doctors, nurses and allied health workers. Family and carers are also supported with emphasis on a holistic approach.

No one is abandoned and everyone can be assisted or supported in some way.

Mr Andrew Denton also claimed at the recent ‘Communities in Control 2017 Conference” in Victoria, that because Catholic thinking holds that suffering can sometimes be of benefit to the person, Catholic Health Care service providers and Palliative Care professionals are deliberately under-medicating symptomatic patients at the end of life. This false assertion implies that professionals in these services are deciding that their patients should experience pain and suffering because it is somehow good for them.

It is contrary to fact that any Palliative Care service or its employees, of any faith or secular belief, would behave this way. The approach to Palliative Care across all

Australian and New Zealand services is held to professional standards, with rigorous and transparent quality control and benchmarking, contributing to our high world ranking.

One has to question the targeting of services and professionals providing the majority of the care and support of those who are terminally or chronically ill, and their families.

Ironically, Mr Denton and others simultaneously claim that Palliative Medicine sets out to end peoples' lives in the guise of giving pain relief. Both claims are false. Research has shown beyond doubt that therapeutic doses of opioid medications and sedatives in palliative care settings do not shorten life. The often-repeated claim that Palliative Care professionals purposely shorten the lives of patients with medication and other practices is untrue, and risks discouraging terminally ill and vulnerable patients from seeking the assistance of Palliative Care, or from taking the very medication which would ease their pain.

As defined by the World Health Organisation and re-stated by the Australia and New Zealand Society of Palliative Medicine, the discipline of Palliative Care aims "to improve the quality of life of patients and families facing 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, psychological and spiritual." Good end of life care, supported by the skills and expertise of Palliative Care professionals, also enhances a person's choices, including the individual's choice to refuse life-prolonging, or other medical treatments unacceptable to that individual.

All Australians should have the confidence that their care and support in their time of need will be defined by this approach, and not by the ill-advised and erroneous observations of those who are rushing to legalise assisted suicide.

For the sake of public confidence, we ask that all sides of the current debate respect the role of Palliative Care services and the dedication and competence of all the professionals that staff them.

If assisted suicide or euthanasia laws are ever considered by our parliaments, that consideration should not be based on the false belief that we cannot assist or support those with pain and suffering in a professional and ethical manner.

If there is a problem facing Palliative Care in Australia it is that access to high quality services is not yet universal. We therefore warmly welcome the commitment of the New South Wales government to provide an additional $100M to the sector focussing on rural and regional service delivery. We call on the Victorian Government to support the call by Palliative Care Victoria for $65M recurring funding to assist the service to provide care for those in need.

It would be unethical for any state jurisdiction in Australia to move to legalise for assisted suicide or euthanasia whilst many ill, aged and disabled Australians cannot yet access the support that they need. Such a move would not enhance choice, but instead reduce choice around the care and support for those in real need..

We call all Victorian legislators to recommit to Palliative Care and the other services needed to better benefit all Victorians, and not to let others' agendas undermine more pressing Health Care and Community Service priorities.