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Health and Environment Committee
Parliament House
George Street
BRISBANE QLD 4000

By email: hec@parliament.qld.gov.au

Re: **Voluntary Assisted Dying Bill 2021 (Qld)**

Thank you for the opportunity to make a submission regarding the Voluntary Assisted Dying Bill 2021 (Qld). I am a health lawyer with 15 years' experience in private practice, and an academic in the School of Law at the University of Notre Dame Australia. I have undergraduate degrees in both Law and Nursing and Masters' degrees in both Law and Bioethics. I am finishing my doctorate which focuses on an empirical study of the attitudes and experiences of doctors with a conscientious objection to abortion who practice in NSW and Victoria.

The views in this submission are mine and do not necessarily reflect those of the University.

I made a submission to the former committee in 2018 **against** legalising euthanasia/physician assisted suicide. I did not make a submission to assist the QLRC in 2020, as it was tasked with developing a legal framework to make euthanasia/physician assisted suicide lawful healthcare. As I cannot support any bill which achieves this end, this short submission focuses on the conscientious objection clauses for health practitioners, which is the area of my research.

Conscientious Objection – Clauses 16, 84, 85

1. Queensland has a *Human Rights Act* which requires its laws to respect freedom of conscience. Limitations on this freedom are permitted, however, where they are considered reasonable in a democratic society. The principles which underpin this bill include clause 5(c), which provides that a person's autonomy, including their autonomy to end their life via VAD, should be respected; and clause 5(h) which provides that a person's freedom of thought, conscience, religion and belief and enjoyment of their culture should be respected.

2. The issues raised by the conscientious objection clauses in this bill are whether they place an inappropriate burden on conscientious objectors and whether they are the only means to achieve the end of equitable access to VAD by the community.

3. There are a range of views in the community regarding the ethics of euthanasia/physician assisted dying and this bill. We should therefore expect a similar range of views within the medical and healthcare professions. Some health care workers have a conscientious objection to VAD and some will refuse to participate in or facilitate it, by direct or indirect actions in the workplace.

4. If Queensland enacts laws for VAD, it must not only consider if there are enough doctors willing and able to assess, prescribe, and administer lethal drugs to patients to meet the demand created by legislation, but that people can locate these doctors. The same applies to speech pathologists who may be required to assist with a person communicating their decision about requesting, confirming or withdrawing their consent to VAD. It may well also apply to other healthcare workers not envisioned by the QLRC who will nonetheless be involved with achieving VAD for a patient.

5. The notion of conscientious objectors taking on the burden of providing information to patients about health care practitioners who do not have a conscientious objection to VAD is an infringement of the objector's fundamental freedom. This is conceded in the Statement of Compatibility. According to the Statement of Compatibility, its justification is that it is the only way to ensure equitable access to services.

6. Consideration was given by the QLRC to a number of options including the position taken in Canada which requires conscientious objectors to provide an 'effective referral'. In *Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontari*o, 2019 ONCA 393; (2019) 147 OR (3d) 444, [113] the Canadian Court of Appeal held that vulnerable patients needed direct personal assistance from their doctors, whom they trust to act as their navigators for health care service.

7. The bill, however, professes to take the 'middle ground' where the conscientious objection is described as 'providing information' rather than an 'effective referral' and where their duty to provide information can be discharged in two ways:

    a. (a) providing information to the patient about another practitioner whom the objector thinks is likely to provide VAD services (or in the case of a speech pathologist, information to their employer); or
    b. (b) providing information about a VAD navigator, a third party who gives the patient an 'effective referral' (this option does not apply to speech pathologists).

8. Option (a) is not guaranteed to ensure the patient will be put in contact with a healthcare practitioner who will provide the VAD service. No guidance is given in the Explanatory Memorandum about how the conscientious objector will achieve this end of locating a non-objecting practitioner, and what level of enquiry needs to be made by them of their peer's views on VAD generally or VAD for the particular patient. There seems to be an assumption that the objecting doctor has some special knowledge on how to locate a non-objecting doctor. The more fulsome the enquiry becomes by the objector, the greater part they play in co-operating with VAD; something the objector sees as highly unethical and the antithesis of medicine.

9. Clearly, option (b) has a higher prospect of achieving access to VAD in a timely way. The VAD Navigator will have no concerns about making enquiries and will have access to the details of practitioners who can assist.

10. The question then is what is the value of imposing option (a) on conscientious objectors? The Statement of Compatibility concludes that no alternatives would impose a lesser burden on human rights, and as such, the requirements in clauses 16(4), 84(2) and 85(2) of the Bill 'are necessary to achieve their purpose of equitable access to health services.'

11. However, this conclusion is not based on any research or data. We simply do not know:

    a. Whether and in what way a patient's access to VAD is decreased by requiring the patient to contact a VAD navigator on their own; and

    b. What harm befalls the Queensland conscientious objector who must go against conscience and assent to the patient's request for VAD by giving the patient information on how to contact a VAD navigator or someone they think will assist them with VAD or in the case of speech pathologists, by giving their employer information about another practitioner they think (but not certain) is likely to assist the patient with VAD.

12. Accordingly, option (a) should be deleted on the basis that it is unnecessary to achieve the bill's end.

13. One of the findings in my doctoral research on the attitudes of doctors with a conscientious objection to abortion in NSW and Victoria was that those who had a conscientious objection to referral were concerned about the quality of information patients might receive about the alternatives to abortion given that it is almost impossible to be 'neutral' and involves differing worldviews about morality. Whilst the bill requires the co-ordinating doctor and consulting doctor to complete approved training, it is unclear what that training will be and this can be central to concerns objectors have about referral and their acceptance of option (b) as a reasonable compromise.

14. If we are a truly tolerant society, we would respect the scope of healthcare practitioners' conscientious objection and try to find the least restrictive means to achieve access to VAD so as to avoid placing an unnecessary burden on individuals.

15. The Statement of Compatibility for this bill notes that patients should not bear the burden of managing the consequences of doctors' religious objections. If this is accepted, it does not mean that the solution lies with placing the burden on the conscientious objector. Rather, as it is the State which has decided to make VAD lawful healthcare, it is appropriate that the state be responsible for ensuring supply of services.

16. The State should ensure that the existence and function of the VAD navigator service is known by the public. This would abrogate the requirement for objectors to try and find another practitioner who is likely to provide the service in question and would educate the public that in a civilised society, the fact that VAD is legal does not mean

that every doctor must be involved with it. This shifts the burden under clauses 16(4), 84(2) and 85(2) of the bill to the state through the VAD navigator.

Given time constraints I am unable to address further issues of limitations on institutional conscientious objection, but I thank you for your consideration of the points set out above.

Your sincerely

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