




Speech By
David Janetzki

MEMBER FOR TOOWOOMBA SOUTH

Record of Proceedings, 14 September 2021

VOLUNTARY ASSISTED DYING BILL

 **Mr JANETZKI** (Toowoomba South—LNP) (Deputy Leader of the Opposition) (12.37 pm): Rarely are we faced in this parliament with a decision that challenges centuries—no, millennia—of custom, practice and law. They are grave questions—how we live and die—and profound in their nature. They are the deeply felt emotions of loved ones, anger at needless suffering and the desire for mercy and dignity. This House must now consider whether the bill before us will be passed. If, as I expect, it does pass, does it then have the necessary protections and safeguards, and have we fully considered the implications of casting aside over 2,000 years of medical ethics and our legal system’s prohibition on the intentional taking of another’s life?

I assure my constituents that I have searched my conscience in relation to these matters. I will not be supporting the bill. I accept that many of my constituents will disagree with my opinion, but I have sought to act in good faith and have engaged deeply with many of the conflicting legal, medical and ethical implications embedded in the bill.

It has been said by the House of Lords that society’s prohibition of intentional killing is the cornerstone of law and social relationships, that an erosion of this principle changes things subtly. Unintended consequences arise. Death results in possessions and privileges passing to others and these others may not be necessarily objective or disinterested observers.

Elder abuse manifests in many ways including emotional and financial pressure, whether that be discussions about bills, wills, mortgages, health costs or supported living. This abuse is made manifest not just in what is said. Withdrawal, neglect and absence are tragically hallmarks of elder abuse. The seminal House of Lords euthanasia inquiry stated that vulnerable people—the elderly, ill, frail or distressed—would feel pressure, whether real or imagined, to request early death. As the Australian Medical Association’s Michael Gannon said in 2017—

The sick, the elderly, the disabled, the chronically ill, and the dying must never be made to feel they are a burden.

He went on to say that it is commonplace for patients to advise doctors, in front of their loved ones, that they do not want to be a burden on their families. I have seen it said in my own family.

Across the nation many in the medical community, so relied upon and trusted when advising on COVID-19, are seriously concerned about VAD. The Australian Medical Association has clearly asserted that doctors should not be involved in interventions that have as their primary intention the ending of a person’s life. The World Medical Association echoes this view, as do the vast majority of nations and national medical bodies across the globe. For 19 former AMA Queensland presidents to take the extraordinary step of writing an open letter opposing VAD says much about their ethical concerns.

I rarely invoke slippery-slope arguments as they generally offend reason and critical thinking. However, I believe the evidence supports the raising of the risk of scope creep. That is because scope creep is obvious to anyone observing the few jurisdictions that have legalised VAD over the past 30 years. The challenge is that once VAD is accepted for a limited subset of examples there is no logical

or philosophical argument to cease expanding categories. If it is legalised for patients with a terminal condition in order to alleviate suffering then why not alleviate suffering for those whose condition is not terminal? On the issue of consent, why limit access to adults if mature children can give consent, as they do in various other contexts? If advance health directives are relied upon to cease certain medical treatments, why should they not be used to support euthanasia? Indeed, at a public hearing in 2019 a Dying with Dignity representative urged the consideration of those very issues for minors and those living with dementia with an advance health directive.

Starting from a similar legislative standpoint as we in Queensland do here today, Belgium now allows children, known as 'mature minors', to access VAD if they are competent. There the criteria has now moved from intractable and unbearable pain towards criteria that have permitted lawful VAD for chronic fatigue, manic depression, anorexia and autism. In the Netherlands a patient does not need to be terminally ill. There, too, VAD is lawful for minors over 12 years of age. Further, a patient may not need to be competent when voluntary VAD is carried out if a valid advance health directive was completed when they were competent.

I could not speak on this bill without addressing personal choice. It is true that freedom of choice is a fundamental philosophical value that I hold dear, but freedom is always freedom within limitations. Those who support this bill, including some friends and colleagues of mine, argue quite justifiably and cogently that institutions have no grounds to exercise conscientious objection, that bricks and mortar cannot hold moral beliefs as individuals do. The countervailing view is that institutions may arguably constitute a gathering of people organised around roles and relationships for social good or that they may provide services on the basis of their identity or moral principles and can, therefore, choose what services they may or may not provide. In any event, my perspective is that VAD is an act that significantly and profoundly involves others and, accordingly, is not just a personal choice as it has public relevance.

Tellingly, the bill requires facilities such as St Vincent's and St Andrew's hospitals in Toowoomba to allow any stage of the VAD process to occur at their facilities, accept that a VAD practitioner may access their facilities at any time and permit the VAD practitioner to decide whether any transfer may occur. This was a statutory direction not even contemplated by QUT professors White and Willmott, who have commented that limiting the ability of institutions to object to VAD was novel and an Australian first. That being acknowledged, my view is that any person working or being cared for in one of those facilities is, in fact, denied their personal choice under this bill. Administrative staff, doctors, nurses, other clinical staff, patients and, in particular, patients in shared accommodation may be exposed to VAD in some way. I note that, similarly, those 19 former AMA Queensland presidents have warned—

It would be wrong for legislation to protect the choice of the one patient on a very rare occasion but disregard the choice of the many thousands of patients and staff who on a daily basis choose to be treated or to work in institutions that do not support VAD.

Others will take a different view when weighing these competing interests, but that is my reasoning.

My belief is that our state needs a hospice and palliative care funding revolution to alleviate pain and distressing symptoms and to provide patients with as much quality of life as possible, to honour the dignity and value of life and help a person die with peace of mind, surrounded by loving care. If only every corner of Queensland could have a Toowoomba Hospice in their community. There is no more respected institution in my city and I thank them for their leadership.

Paul Keating has proffered that the stringency or conservative nature of the safeguards miss the point. He points to the core intention of the law and the ethical threshold being crossed. He argues—

It is a mistake for legislators to act on the deeply held emotional concerns of many when that involves crossing a threshold that will affect the entire society in perpetuity.

Yet VAD continues to be legislated disparately by parliaments across our federation, each siloed from the other in a seeming regulatory vacuum. Whether it be conscientious objection, coercion risks, specialist medical advice, reporting requirements or time frames, there is a need to improve this bill and I seek to be constructive in my aspiration. That is why, despite my opposition to the bill, I will be moving amendments during consideration in detail. There are 54 amendments now circulated and I table them for the House.

Tabled paper: Voluntary Assisted Dying Bill 2021, amendments to be moved by Mr David Janetzki MP [1375](#).

Tabled paper: Voluntary Assisted Dying Bill 2021, explanatory notes for amendments to be moved by Mr David Janetzki MP [1376](#).

Tabled paper: Voluntary Assisted Dying Bill 2021, statement of compatibility with human rights for amendments to be moved by Mr David Janetzki MP [1377](#).

These amendments draw on stakeholder suggestions from, among others, the Queensland Law Society, the Bar Association, AMA Queensland, Palliative Care Queensland, Catholic Health Australia, the Royal Australian College of Physicians and the Queensland Human Rights Commission. The

amendments seek to enhance safeguards and reporting through aligning the proposed laws before this House to provisions adopted in other jurisdictions, including South Australia, Victoria, Western Australia and New Zealand. We in this House have a heavy obligation to Queenslanders in relation to this bill. Let us not be derelict in our duty to discharge it.