Speech By

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MEMBER FOR OODGEROO

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VOLUNTARY ASSISTED DYING BILL

Dr ROBINSON (Oodgeroo—LNP) (3.34 pm): I rise to contribute to the Voluntary Assisted Dying Bill 2021 on what is a very complex, difficult and personal issue. The debate has mostly been respectful and allowed people to express their strongly held differing views. I thank those who have engaged respectfully with me—those for and those against.

Every story told of end of life by people of opposing views must be heard and respected. I, too, have lost loved ones from the insidious evil of cancer and this loss forms part of my view. As fellow humans we must first feel with our hearts and then as legislators we must do the hard work and go beyond the raw emotions and strong feelings generated by the loss of loved ones.

The tough question we are faced with today is: does this bill provide better health care for the terminally ill suffering from intolerable pain? We must go beyond the single issue of autonomy to ask broader medical, legal, social, ethical and religious questions.

In terms of findings and recommendations, in my dissenting report I outline them. I formed the view that this bill is not safe, it is not good law, it does not solve the critical issues of end of life and creates a range of unacceptable outcomes, risks and dangers, now and into the future. My dissenting report considers the main purposes of the bill in the light of its detailed provisions, the submissions and evidence presented to the committee and the experience with similar legal schemes elsewhere. This speech seeks to summarise it and more detail is provided in my dissenting report.

One of the things in that report is that medical authorities mainly oppose the bill. This bill, if passed, would introduce into Queensland practices that the World Medical Assembly, the WMA, opposes. After extensive international consultation with its 115 national medical associations which constitute it, the WMA reaffirmed in October 2019 that euthanasia and assisted suicide laws were contrary to medical ethics and should be opposed. The Australian Medical Association likewise affirms that doctors should not be involved in interventions that have, as their primary intention, the ending of a person's life. When we consider the end-of-life medical authorities like Palliative Care Queensland, the Queensland Directors Palliative Care Group and most palliative care specialists, they point out that if palliative care was adequately funded, which it is not, and there was equitable access for all Queenslanders, which there is not, then terminally ill Queenslanders would have the improved quality of life they need while living with a life-limiting illness and having the relief of suffering through early identification, effective assessment and treatment of pain and other problems.

This bill is not coming from the medical authorities, not from those we trust with our health. VAD is not driven by a medical agenda. It is sadly, in my view, more about a political agenda, and there is more of that to come.

The committee heard that the majority were opposed. Of the 6,000 or so submissions received by the committee from separate individuals and organisations, a majority of 57 per cent were opposed to the VAD Bill while only 43 per cent were for it. Further, we know that there is great concern about assisted suicide in our multicultural and multifaith communities—Queenslanders from diverse cultural

and faith backgrounds—First Nations peoples, migrant and ethnic communities. It is also opposed by multifaith communities such as Muslim, Jewish and major Christian denominations—in total, many millions of Queenslanders.

My dissenting report makes eight findings and five recommendations. Finding No. 1 is in terms of intentional killing. It finds that the bill would make it legal for one person to take the life or help end the life of another person, or to counsel or help another person to take their life. The bill creates exceptions to prohibitions in the Criminal Code dealing with acts where the person intends to cause the death of another person and counselling and the act of aiding suicide. The exceptions include the administering of a poison from the S4 or S8 poison schedule to a person of sufficient dose to cause death, and with the explicit intent of causing death. I agree with former Labor prime minister Paul Keating with respect to the intentional killing of the vulnerable, that this is a threshold that we dare not cross, because once the state sanctions death and allows that deliberate act to be redefined as a medical treatment, once we cross that line, there is no going back.

The bill also creates the legal situation that a person who takes their own life through self-administration of the poison does not die by suicide. Clearly an individual taking their own life by VAD is still a form of suicide.

Finding No. 2 is the impact on suicide prevention. The bill would increase the number of suicides in Queensland as opposed to reducing them, in my view. Based on what we know around the world where VAD type laws are introduced—like the Netherlands and Canada—suicide numbers do not go down but continue to climb. Some claim it would be different. If we look at the example of the first year of VAD in Victoria, 2020, there was a recorded 25 per cent rise in suicides over the figures for 2017.

Finding No. 3 relates to eligibility. The bill fails to ensure that only eligible people will be able to access assisted suicide or euthanasia. The lack of any requirement for the coordinating or consulting practitioner to have any qualifications or experience relevant to the treatment and care of a person with a specific disease, illness or medical condition makes it inevitable, as elsewhere in the world, that there will be errors made in the accuracy of the diagnosis and prognosis, as good as our doctors are. Further, eligibility requirements in other countries, like the Netherlands, have slipped from an emphasis on the terminally ill suffering intolerable pain, as Dr Philip Nitschke reported to the committee, to anyone for any reason so long as they are of sound mind, as is the current case in Switzerland—people who are tired of life.

Finding No. 4 relates to all treatment options. The bill fails to ensure that patients are offered all options to manage their illness prior to the commencement of any life-ending procedure. The bill fails to ensure that before a person is euthanised that the person is offered all effective, available treatment and likely outcomes for the person's disease, illness or medical condition.

Finding No. 5 relates to suffering and intolerable pain. The bill fails to adequately define suffering to limit it to intolerable physical pain. The inclusion of 'mental suffering' and the phrase 'that the person considers intolerable' expand eligibility well beyond cases where there is actual physical suffering that cannot be relieved. There are many jurisdiction such as Oregon, Canada and even Victoria where we see that to be already the case.

Finding No. 6 relates to mental illness and decision-making capacity. The bill provides inadequate protection to those affected by a mental illness. Provisions relating to determining decision-making capacity are insufficient to guarantee that no person is wrongly assessed as eligible, including persons with treatable mental illnesses such as clinical depression. One study in Oregon found that one in six applicants who died under Oregon's euthanasia laws had clinical depression. Over the 23 years of Oregon's laws, it is likely that around 250 people with clinical depression were euthanised without being referred for a psychiatric evaluation.

Finding No. 7 relates to coercion. The bill fails to protect the vulnerable from coercion and undue influence. Provisions relating to determining whether a person is acting voluntarily and without coercion are insufficient. Evidence from Canada, Washington State and Oregon confirm that feeling a burden on family is a reason for requests for assisted suicide. The obvious question to ask is whether this concern may be influenced by others. The recent Morant case in Queensland shows that selfish individuals have and will coerce family members to take their own life for their own advantage. When we combine this with VAD, it is dangerous territory.

Finding No. 8 relates to complications in dying by VAD. The bill fails to safeguard the vulnerable from prolonged, complicated or painful death as a result of the administration of the poison. It is assumed that any death brought about under the bill's provisions would be both rapid and peaceful. However, as outlined in my dissenting report, there are many cases where that is not the situation. The research shows that.

I have also made five recommendations. Recommendation 1 is that the bill not be passed. Recommendation 2 is that if the bill is to pass that it be amended to leave all health practitioners in Queensland free to exercise good practice. Recommendation 3 is that entities such as private hospitals and residential aged-care facilities should be allowed to opt out and not be forced to participate, as the bill does make them participate in some way, in a practice that they find incredibly offensive to them and their faith community. Recommendation 4 is preventing suicide in any form being an offence as this bill makes it in some cases. Recommendation 5 calls for Commonwealth law to remain in force to continue to protect vulnerable Queenslanders, particularly those in rural and regional Queensland, from pressure to participate.