Addendum to Submission 84

Critical Issues Relating to Voluntary Assisted Dying Bill 2021

Without being exhaustive, I submit that the persons and institutions most involved on a daily basis with the care of the dying, are, at best, lukewarm as regards the VAD Bill, if not completely opposed.

Submission No	Organisation/Individual
25	Palliative Care NSW
29	Avant Mutual
52	Sydney Institute of Palliative Medicine
54	Little Company of Mary Healthcare (Calvary)
55	Anglicare Sydney and Anglicare Northern Inland (together with 42 Anglican Church Diocese of Sydney
57	Australian and New Zealand Society for Geriatric Medicine – NSW Division
65	Dr Frank Brennan, palliative care physician
66	Dr Sarah Wenham, palliative care physician, Broken Hill
69	MIGA (Medical Insurance Australia)
70	Australian and New Zealand Society of Palliative Medicine (ANZSPM)
71	Palliative Care Nurses Australia

Michael McAuley BA, LLB, M Bioethics has been a barrister in practice since 1984. He is Professor of Law at the University of Notre Dame Sydney, and President of the St Thomas More Society. This submission draws on discussions with various medical practitioners

Submission No	Organisation/Individual
74	Australian Medical Association (NSW)
75	St Vincent's Health Australia
77	Catholic Health Australia
78	Associate Professor Megan Best
81	Clinical Professor Richard Chye, palliative care physician
87	Professor David Kissane
91	Dr John Obeid, geriatrician
92	Dr Stephen Parnis, emergency physician
102	Royal Australian & New Zealand College of Psychiatrists

Also pertinent are the comments in submission 72 from the Department of Health, Victoria, and the Report of Operations January – June 2021, Victorian Assisted Dying Review Board. The submission of Dr Sarah Wenham, a palliative care physician based in Broken Hill, is particularly troubling as to the absence of reach of palliative care in NSW, even in metropolitan areas.

Rejection of Specialist Medical Knowledge and Practice

The Opposition to the VAD Bill from those with most specialised, both practical and medical, experience should give even VAD's most determined supporters pause. The argument for VAD largely involves a rejection of contemporary specialist medical knowledge and practice.

Those who, day in, day out, deal with the aged, the very sick, the very disabled, and dying patients have most to contribute to this debate.

In this context, lawyers can usefully highlight particular provisions of the Bill, and how those provisions may work in practice. Lawyers can highlight how the Bill may impact the culture of doctors and nurses, and institutions providing care to the aged, the sick, the disabled, the dying. But it is those with the most specialised knowledge and experience who have the most to contribute to the debate.

No	Issue
1	**Voluntary Assisted Dying Board**
	• **Lack of independent scrutiny**. • **Inadequate medical representation** on Board. • **Inadequate recording** of information. • Review of Act should be by independent person, not at behest of Minister. • **Ombudsman** should be able to inquire. **Bill** Part 10 Voluntary Assisted Dying Board 143 Membership 144 Chairperson and deputy chairperson 170 Board to record and keep statistical information 185 Review of Act Schedule 1A.4 Ombudsman Act
2	**Yet another "option"**
	• VAD is not an equivalent to palliative care. • VAD is not a "treatment option". • Header to s 10 is misleading. **Bill** 10 Healthcare Worker Not to Initiate Discussion about VAD

No	Issue
28 Information to be Provided if Patient assessed as meeting eligibility criteria 41 Recording and notification of consulting assessment	
3	**Presumption of capacity**
• Section 6(2) is inconsistent with contemporary medical knowledge. • Section 16(1)(e) is inconsistent with contemporary medical knowledge. **Bill** 6 Decision-making capacity 16 Eligibility criteria	
4	**Eligibility**
• Section 16 is inconsistent with contemporary medical knowledge. **Bill** 6 Decision making capacity 16 Eligibility criteria	
5	**Absence of involvement of specialists-geriatricians, palliative care specialists, neuro-psychologists, psychiatrists**
• **GPs do not have the knowledge, training or experience** of specialists in palliative care, geriatrics, oncology, neurology, psychiatry, and neuropsychology. • The VAD Bill is consistent with movement from **personal and professional model** of healthcare, underscored by an ethical base, to an **impersonal bureaucratic model.** • The absence of a **mandatory detailed report**, taking into account medical history including reference to medical records, is concerning. **Bill** 18 Eligibility to act as coordinating practitioner or consulting practitioner	

No	Issue
55 Eligibility to act as administering practitioner	
6	**Absence of involvement of treating doctors**
Bill 18 Eligibility to act as coordinating practitioner or consulting practitioner 55 Eligibility to act as administering practitioner	
7	**Absence of detailed written report addressing criteria-computerised tick and flick with coordinating & consulting practitioners being close colleagues**
Bill 16 Eligibility criteria	
8	**Absence of requirement to consider medical history including medical records**
Bill 15 When person may access VAD 16 Eligibility criteria	
9	**Impersonality of procedures**
Bill 19(3) Request 176 Audio visual communication 177 Electronic signature 186 Interpreters	
10	**Absence of involvement of family**

No	Issue
	Bill Part 3 – Requesting access and assessment of eligibility 108 Eligible applicant 109 – Review of Certain Decisions by Supreme Court
11	**Sham provisions re conscientious objection-consideration of series of trip wires directed at doctors which have caused medical liability insurers concern**
	• Section 9 provides **no real protection** given other provisions of the Bill. • Section 9, when considered with Part 5, demonstrates a **determined effort to drive faith-based persons and institutions from care of the dying.** **Bill** 9 Registered health practitioners may refuse to assist in VAD 11 Contravention of Act by registered health practitioner 21 Medical practitioner to accept or refuse first request 22 Medical practitioner to record 23 Medical practitioner to notify Board of first request 28(1)(k) Treating practitioner 32 Medical practitioner to accept or refuse referral for consulting assessment 33 Medical practitioner to record referral and acceptance or refusal 34 Medical practitioner to notify Board of referral
12	**Faith-based hospitals & residential care**
	• The heading to Part 5 is a **misnomer.** • Part 5 is directed to **drive** faith-based institutions **out** of hospital, disability and aged care.

No	Issue
	• Part 5 must be considered in the light of the ethical concept of cooperation – formal, material, immediate material, mediate material, remote material – and the principle 'do no wrong.' • Part 5 places **very great burdens** on faith-based establishments and presents them with ethical quandaries. • Faith-based institutions provide some of the best care available. It is not in the **public interest** that they be driven out. **Bill** Part 5 Participation 89(1) Participation in providing voluntary assisted dying services Division 2 – Residential Facilities 90 Access to information about voluntary assisted dying 92 First and final requests 93 First assessments 94 Consulting assessments 96 Application for administration decision 97 Administration of voluntary assisted dying substance 98 Relevant entities to inform public about non-availability of voluntary assisted dying Division 3 – Healthcare Establishments 101 First and final requests 102 First assessments 103 Consulting assessments 104 Written declarations 105 Application for administration decision 106 Administration of voluntary assisted dying substance

No	Issue
107	Relevant entities to inform public about non-availability of voluntary assisted dying
13	**Delegation**
	• Bill ought provide, as a minimum, that exercise of these functions should be drawn to the attention of Parliament with provision for disallowance. **Bill** Part 11 (174) – Access Standard 180 Health Secretary may approve training, information and other resources 181 Guidelines 182 Health Secretary may approve forms
14	**Protection from liability**
	Bill Part 9 Protection from Liability
15	**Advocacy**
	Section 10(1) and (2) are contrasting. **Heading to s 10 is misleading.** **Bill** 10 Healthcare worker not to initiate discussion about VAD 174 Standard about access to VAD 178 Information about VAD 179 Official VAD Navigator Service
16	**Likelihood of continuing campaigns for ever widening criteria & classes of persons**

No	Issue
	• Section 16 is so indeterminate that it will give rise to **continuing campaigns** for 'liberalisation.' **Bill** 16 Eligibility criteria
17	**Shift from professional model of care to bureaucratic model**
18	**Shift in culture** (Hippocratic Oath/Good Samaritan) of medical & nursing professions