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Health Professionals Say No is an independent secular network of over 880 healthcare professionals dedicated to the care of the seriously ill, aged and dying, with 430 being represented from NSW. Our experience ranges across all healthcare sectors and regions inclusive of psychosocial care. Many of us have been, or are still, in coalface and leadership positions associated with NSW Health and other significant care institutions, including community services. Between us, we have cared for hundreds and hundreds of thousands of individuals with life limiting, mental health and aged conditions.

As a group, we are at times incredulous at how our knowledge and experience is often brushed aside by some in the media, proponent lobby groups, and those in the political sphere, when we try to rationally explain with hard and true evidence, that euthanasia and physician assisted suicide legislation represents a minority world view and socio-political agenda, that should not be imposed onto health care and psychosocial services or institutions, due to the harms it would create.

We are also concerned by the rapidity of the uptake of such Bills in Australia, despite it being a minority view, and for Australia, an untested trend that already is demonstrating distress in the ambiguity created in health care environments, fears of or confusion around of what constitutes palliative care, and even evidence of wrongful deaths through coercion. There are only 16 world-wide jurisdictions with such legislation, 5 of which are in Australia. If one examines the USA alone, where the Oregon model exists, 88 bills have been rejected in the last

4 years, with legislation reversed in New York the same year the Victorian Bill was passed, because of concerns around safety and the negative impacts toward those in need of healthcare and social services, as well as the resultant degradation of services. There have been and are many reasons demonstrable for why NSW should not follow this trend. We have an opportunity for discernment here in NSW that should not be wasted.

We add to this also the scaremongering created by misrepresentation of coronial statistics on suicide in the seriously ill, which do not serve to inform NSW citizens of what can be availed and what should occur instead. The claims that VAD will eliminate suffering are illusory only, as dissection of this information demonstrates that most of these assumed bad deaths as claimed in Victoria, and now in NSW, would not have been prevented by VAD legislation, and in fact, that may have not occurred if referred to appropriate psycho-social or palliative care services.

We also see emotive or subjective interpretations of what the legislation represents above true representative opinion polls and majority world view, which show that Australians would actually want access to general service provision and palliative care addressed ahead of VAD legislation, and as we do. Australians also harbour concerns about the lack of safety inherent in VAD Bills for the vast majority of vulnerable individuals in need of that care. This Bill also is contrary to what is actually recommended by major Australian and NSW inquiries toward the safe provision of that care. Our written submission has also provided evidence of this.

Specifically, the NSW Bill has far-reaching implications and requires major legislative changes in criminal, coronial and health care regulatory acts, that make mistakes, abuse and coercion more likely. Significantly, ^{there are prejudices} ~~the~~ inadequacies in ^{there are} processes with regards to patient assessment, provision of a poison, lack of detailed medication safety processes and record keeping, assumptions in the witnessing process, brief turnover period prior to suicide, and the allowing for a patient to be euthanised, all create potential for abuse and errors, not to name problems for investigations of wrongful practices or breeches by the Health Secretary, and also erosion of the Coroner's ability for investigation.

Euthanasia and physician assisted suicide are not part of evidenced good end of life practices or palliative care. Nor are they medical treatments and not made so through an individuals' assertion of autonomy, which is then described as "choice". Healthcare professionals, institutions and care workers are not agents of the State for a socio-political agenda, which this Bill is.

The practices within this Bill and expected of clinicians, health and care workers and institutions, are contrary to standards of safe and ethical clinical practices, conduct and guidelines. The approach to process in this bill is devoid of the usual rigor of history taking, clinical investigation and /or management and referral necessary for a best practice approach, patient safety and quality assurance. Examples of this are the presumptions made, and lack of adequate process around the determination of competence, mental health and coercive influences in decision making. This would be compounded further by the inaccuracies

inherent in allowing Tele-health assessments to be utilised, and the subjective measure of what is tolerable or intolerable for a given individual or their relatives.

Another example is in a doctor being able to endorse or suggest suicide, even if that doctor's attitude or behaviours creates undue influence toward suicide by their action or demonstrable attitude, and even from a doctor with no expertise, experience or qualifications to service that person's needs. These circumstances are also contradictory of the preamble claims of the Bill around undue influence. We have also provided evidence of what this means in our submission to patient's decision making, including the fostering of fears that may never eventuate or can be managed or prevented, reinforcement of a sense of burden or hopelessness, or by leaving depression, which is common, untreated.

It replaces good practice and care with inaccurate assumptions and a bureaucratic tick box of expectations in conduct, which give preference to euthanasia and assisted suicide. The result is an upward coercive influence toward suicide, rather than the usual clinical rigor and care expected of clinicians, health care and care workers when faced with these requests or expressed desires.

It is also contrary to evidence, and our almost universal experience, that when the reason for the request of hastening is explored, appropriate and compassionate care or appropriate referral is given, along with symptom management and advance care planning, patients' fears and desire to die diminish and distress dissipates. People usually change their minds, and their sense of suffering is relieved. Quality of life, hope and outlook, meaning and sense dignity is usually

restored with medical and psychosocial care and accompaniment. Many re-gain some control again, over their lives. Further, distressed relatives and carers can be supported in their experience with the patient. We have daily examples of this through our usual working week.

This Bill is not neutral and is not just about 'choice'. There are, for example, no safeguards for the majority of patients or vulnerable to this legislation and their doctors or institutions of care. Protections and sanctions are illusory and unenforceable. The limited mention of "conscience", without any true rights around the expression of sound professional objections, is another example here. Institutions, doctors, nurses and care staff would be expected to be complicit in actions against their professional ethics and usual standards or knowledge and approaches to safe patient care, creating work-spaces filled with tensions or conflicts, imposed on often already challenging normal circumstance. This would further compound what have seen recently in trying to deal with the conflicts, stresses and distress produced by pandemic conditions.

The only real protections afforded by this Bill are for the narrow reference group and the doctors it was designed for.

Priority in NSW should be given to the majority health, aged and psychosocial care agendas ahead of VAD legislation. This includes access and delivery of quality and specialist palliative care, through better funding and modelling arrangements and care of the aged. This Bill does not serve to educate or inform the general public of real and appropriate advocacy for those in challenging life circumstances, or under

duress, nor does it provide true choice for the vast majority of these citizens for their care. This Bill should not be imposed on health care workers or care institutions, inclusive of community services. This Bill does not serve the health care needs or interests of NSW citizens in need of or under our care, and would create a 2 tiered system, which favours the small reference group for which it was written, above larger communal rights and good healthcare practices.