LAW AND JUSTICE COMMITTEE

INQUIRY INTO THE PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Responses to supplementary questions asked of Archbishop Anthony Fisher OP, Archbishop of Sydney, Catholic Bishops of New South Wales and the Bishops of the Australian – Middle East Christian Apostolic Churches

1. ***Assuming the Voluntary Assisted Dying Bill 2021 is passed by the New South Wales Parliament in its current form, including:***

   - ***Clause 9 (and related provisions) – Registered health practitioners may refuse to participate in voluntary assisted dying; and***

   - ***Part 5 – Participation***

   what do you say will be the specific impact on residential facilities and health care establishments operated by your organisation?

The importance of the protection of conscience cannot be underestimated, for a person's conscience is core to their identity. As the Second Vatican Council described:

> "In the depths of his conscience, man detects a law which he does not impose upon himself, but which holds him to obedience. Always summoning him to love good and avoid evil, the voice of conscience when necessary speaks to his heart: do this, shun that. For man has in his heart a law written by God; to obey it is the very dignity of man; according to it he will be judged. Conscience is the most secret core and sanctuary of a man. There he is alone with God, Whose voice echoes in his depths."[1]

A person does not only manifest their conscience individually, but also through associating with others who share the same beliefs. This is evident in Article 18.1 of the *International Covenant on Civil and Political Rights* (**ICCPR**), which provides:

> "Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, **either individually or in community with others and in public or private**, to manifest his religion or belief in worship, observance, practice and teaching." [Emphasis added.]

In health and aged care settings, this association includes those who choose to work or receive care at religious institutions founded on the principles of sanctity of life from conception until natural death and the fundamental dignity of the human person. This is evident in Article 6(b) of the *UN Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief*, which states that the right to freedom of thought, conscience, religion or belief shall include the freedom "to establish and maintain appropriate charitable or humanitarian institutions."

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[1] Paul VI. (1965). *Pastoral Constitution on the Church in the modern world: Gaudium et spes*. Retrieved from http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html

This communal aspect to the right to freedom of religious belief and the related right of freedom of association (Article 22, ICCPR) provide clarity for medical practitioners with respect to the treatment with which they can be expected to provide patients, as well as for patients with respect to the treatment they can expect to receive. This is especially important because patients in hospitals, particularly those at the end of life, and residents in aged care are at their most vulnerable and are thus most dependent on a corporate body to continue to uphold certain standard practices that align with the consciences of the individuals involved.

Attempts in the *Voluntary Assisted Dying Bill 2021* (**Bill**) to protect individual conscience rights while offering little or no protection for those individuals to associate in institutions that are operated in accordance with a particular ethos wrongly presume that individual conscience rights can be adequately respected without also preserving the rights of an institution to maintain ethical policies that align with the consciences of the individuals involved.

Part 5 of the Bill is not only an egregious attack on the religious freedom of religious care facilities, particularly residential aged care facilities, it will result in the undermining of the culture of care in these facilities that have served the people of New South Wales so well. This is especially the case for Part 5, Division 2 of the Bill, which requires a religious aged care facility to allow every aspect of the euthanasia and assisted suicide process, including the administration of lethal drugs, to occur on its site.

Health care is something intrinsic to the Catholic faith. The Catholic Church is the oldest and largest provider of healthcare in the world. From the earliest times of Christianity, believers cared for the sick as signs of charity and hospitality. Christians assisted the sick, particularly in times of plague, and established the first hospitals in the fourth century. Monks established hospices to welcome the sick and fraternities and orders of Christian hospitallers emerged. In early modern and modern periods, hospitals evolved as part of an extraordinary network established largely by religious women and their benefactors.

Today, there are over 5,000 Catholic acute care hospitals and 15,000 nursing and long-term care centres throughout the world, including 11 Catholic hospitals and 59 Catholic nursing homes in New South Wales. These care facilities are not an optional extra for Catholics; they are core to Christ's command to heal the sick (Matthew 10:8) and any attempt to erode their ethos is a threat to religious freedom and also to the important service they provide to the poor, sick and dying.

The establishment of Catholic hospitals and aged care facilities is about more than simply restoring people to health; it is a ministry to the poor and marginalised, the sick and disabled, mediating the healing compassion of God to the world. They stand as a witness to every individual that no life lacks dignity; that every person is worthy of our care and our attention.

For the suffering and dying and their families, Catholic hospitals, hospices and other care facilities provide genuine compassion, the meaning of which is to "suffer with," to those at the end of life and not to limit their care under the guise of efficiency or mercy. Those treated in Catholic facilities can trust that they will be treated with reverence and compassion, even unto death.

No one can pretend that the provision of such care is easy. If the COVID-19 pandemic has taught us anything, it is that serious demands are placed upon our health professionals. The long-term commitment to care for chronically ill and dying patients requires not just sufficient resources and

technical skills, important as they are. It also requires a culture of care that is nurtured at an institutional level.

It is this culture of care that is threatened by Part 5 of the Bill. In requiring some or all aspects of the euthanasia and assisted suicide process to occur on site at Catholic facilities, the ability of those facilities to proclaim the value of every human life is undermined. Not only is this detrimental to the individual resident or patient seeking euthanasia or assisted suicide, it will have a broader effect on the staff and other residents and patients in the same care facility.

In the short term, the impact on staff will be that they will no longer be able to choose a workplace where their ethos of healthcare is respected. Even if not obliged to participate in euthanasia or assisted suicide themselves, they will nonetheless experience their own patients being facilitated to an early death by medical practitioners not otherwise involved in their care. For patients and residents, they will lose the right to choose a facility that reflects their own beliefs and desires for end-of-life care.

In the longer term, however, these provisions will see the weakening of the ethos of the institution itself and its commitment to the sanctity of human life. It will be near impossible for even the best of institutions to insist on such a commitment if staff, patients and residents witness the facilitation of euthanasia and assisted suicide on the premises. The provisions threaten the very identity and *raison d'etre* of Catholic hospitals, hospices and aged care facilities and so their long-term impact would be catastrophic in terms of the care these facilities provide.

Robust protections for individual conscience and the associated right of freedom of association in institutions will simply allow the Catholic Church to continue its service to the suffering and dying, a service which has been provided continually in this state since the Sisters of Charity established Sydney's first hospital in 1857.

2. ***Assuming the Voluntary Assisted Dying Bill 2021 is going to be passed by the New South Wales Parliament in its current form and having regard to:***

   - ***Clause 9 (and related provisions) - Registered health practitioners may refuse to participate in voluntary assisted dying; and***

   - ***Part 5 – Participation***

   what specific amendments do you propose to the Bill that would enable your organisation to continue to perform its work in the provision of Residential facilities (Part 5, Division 2) and Health care establishments (Part 5, Division 3) covered by the proposed legislation?

The right to freedom of thought, conscience and religion is recognised in international human rights law, including under the ICCPR to which Australia is a party. Article 4.2 of the ICCPR states that no derogation may be made from this right, even in times of national emergency.

Further, article 18.3 of the ICCPR states that the freedom of thought, conscience and religion "may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others." There has never been a recognised right to die and certainly never a right to require others to facilitate a person's death.

Despite the clear priority for rights of conscience and religion contained in international human rights jurisprudence, the Bill in its present form does not sufficiently protect individual conscience rights or the freedom of association for those who want no part in euthanasia or assisted suicide and seeks instead to subject these rights to a non-existent right to die.

Recommendations 32-39 in the submission from the Catholic Bishops of New South Wales and the Bishops of the Australasian- Middle East Christian Apostolic Churches dated 22 November 2021 provide details of the minimum amendments required to protect rights of conscience. The Committee is referred to these recommendations in the first instance.

More detail on the necessary amendments is provided below.

<u>Clarification that a medical practitioner may conscientiously object at any time in the voluntary assisted dying process</u>

Section 21(5) requires a medical practitioner who holds a conscientious objection to inform a patient "immediately after" the first request is made. Section 32(5) similarly requires a medical practitioner who holds a conscientious objection to inform a patient and coordinating practitioner "immediately after" a referral is made. This presumes that a conscientious objection would only ever arise at the beginning of the voluntary assisted dying process. While that will often be the case, it does not leave room for the conscience of a medical practitioner who may not hold a blanket conscientious objection to euthanasia or assisted suicide, but for whom the circumstances of a particular patient raises issues of conscience. For this reason, the right to respect for conscience should not be time limited.

It is proposed that the following amendment be made on page 4 to subclause 9:

> On line 4, insert ", at any time," after "right to refuse".

Clarification that a medical practitioner is not required to provide information about voluntary assisted dying

In the third reading debate for the Bill in the Legislative Assembly, subclause 21(5) was amended to remove the obligation on a medical practitioner with a conscientious objection to participation in euthanasia and assisted suicide to give a patient information approved by the Health Secretary. In light of this, clause 9 should be amended to make it clear that a medical practitioner is not obliged to provide information to a person about voluntary assisted dying.

It is proposed that the following amendment be made on page 4 to clause 9:

Insert, after line 8—

(aa) provide information to a person about voluntary assisted dying,

Clarification that a medical practitioner may refuse to transfer to another practitioner

Acknowledging that a medical practitioner may exercise rights of conscience at any time, clause 9 should be expanded to specify that there is no obligation on a medical practitioner to transfer the role of coordinating, consulting or administering practitioner if they hold a conscientious objection.

This is not about frustrating the voluntary assisted dying process and it would be likely that a medical practitioner who sought to use these provisions to do so would be subject to claims of unsatisfactory professional conduct or professional misconduct for the purposes of the *Health Practitioner Regulation National Law*. It is rather about ensuring that conscience rights do not diminish as the process moves along.

It is proposed that the following amendment be made on page 4 to clause 9:

Insert, immediately after the amendment described above —

(ba) transfer the role of coordinating practitioner to another person,

(ca) transfer the role of consulting practitioner to another person,

(da) transfer the role of administering practitioner to another person,

It is further proposed that the following amendment be made on page 29 to clause 64:

Insert, after line 37 –

(2A) Subsection (2) does not apply if the original practitioner has a conscientious objection.

It is also proposed that the following amendment be made on page 54 to clause 116:

Insert, after line 27 –

(2A) Subsection (2) does not apply if the original practitioner has a conscientious objection.

Remove the requirement that a medical practitioner must inform anyone other than the patient of a conscientious objection

Subclauses 23(2)(h) and 34(2)(e) require a medical practitioner to inform the Voluntary Assisted Dying Board every time they conscientiously object to participation in euthanasia or assisted suicide. Similarly, subclause 32(5) requires a medical practitioner who has refused a referral to act as a consulting practitioner to notify the coordinating practitioner of their refusal.

These are onerous obligations that do not respect the rights of conscience because medical practitioners who do not wish to participate in certain medical procedures on conscientious or religious grounds can be subject to targeting by activists and even risks to their career progression. A recent article in the *Journal of Medical Ethics* that was co-authored by Professors Ben White and Lindy Wilmott (both euthanasia advocates who drafted the Queensland euthanasia and assisted suicide bill) reported as follows:

> "For junior doctors wishing to exercise a conscientious objection to VAD, their dependence on their senior colleagues for career progression creates unique risks and burdens. In a context where senior colleagues are supportive of VAD, the junior doctor's subordinate position in the medical hierarchy exposes them to potential significant harms: compromising their moral integrity by participating, or compromising their career progression by objecting."[2]

The requirement to notify the Voluntary Assisted Dying Board and other medical practitioners of a conscientious objection is unnecessary and an unjust imposition on conscience.

It is proposed that subclauses 23(2)(h) and 34(2)(e) be deleted, and subclause 32(5) be amended as follows:

Omit subclause 32(5) and instead insert–

(5) If the medical practitioner decides to refuse the referral for a reason mentioned in subsection (2), the practitioner must, immediately after receiving the request, inform the patient and the patient's coordinating practitioner of the decision.

Residential facilities

Freedom of conscience and religion belong to individuals, but in order for these freedoms to be fully respected, the right of freedom of association in institutions that respect conscience and religion must be protected because it is through institutions that individuals often exercise their religious freedoms.

Faith-based residential aged care facilities should not be required to allow any aspect of euthanasia or assisted suicide on their premises because to do so would require faith-based institutions and those who own, operate and reside in them to act against their core beliefs.

Many residents choose Catholic aged care facilities because of their Catholic ethos, particularly the fundamental belief that human life should be protected at all stages. Many families choose Catholic aged care facilities for the same reason. Their choices at the end of life must also be respected. Catholic

[2] McDougall RJ, White BP, Ko D, *et al* Junior doctors and conscientious objection to voluntary assisted dying: ethical complexity in practice. Journal of Medical Ethics Published Online First: 14 June 2021. doi: 10.1136/medethics-2020-107125

aged care facilities must be able to continue to offer residents and potential residents the guarantee that euthanasia and assisted suicide will never be facilitated or performed on site.

The Bill's proposal to require religious care facilities to allow access to medical practitioners to perform every stage of the euthanasia and assisted suicide process on site goes against the duty of care that these facilities owe to residents. The Bill requires doctors and other medical practitioners who are not involved with the day-to-day care of residents nor have any association with the facility to be allowed on site to facilitate the death of those residents, all without informing the relevant institution. This is contrary to the rights of residents and staff at these facilities, many of whom desire to work at a Catholic institution because of its ethos.

To allow proper conscience protections for those who own, operate and reside in aged care institutions, clauses 90 to 97 inclusive must be deleted and Part 5, Division 3 (as amended below) be made applicable to all institutions.

Health care establishments

For the same reasons as outlined above, clause 99 must be deleted in its entirety to allow proper conscience protections for those who own, operate and receive care at health care establishments, which means not requiring any process of the euthanasia and assisted suicide process to occur on site.

Additionally, subclause 102(2) and the equivalent provision in clauses 103-106 inclusive provide that a health entity "must take reasonable steps to facilitate the transfer" of a person wanting to participate in the euthanasia or assisted suicide process. The obligation to take reasonable steps to facilitate a transfer is mandatory. Notwithstanding, the criteria to which the health entity must have regard when making a decision about the reasonable steps that may be taken listed in subclauses 102(3), 103(3), 104(3), 105(3) and 106(3) only pertain whether or not to transfer the patient at all. These considerations would have no bearing on the obligation on a health entity to facilitate a transfer, as it is already mandatory and so these subclauses are superfluous under the current Bill. However, their presence in the Bill clearly foreshadows future amendments that would limit the ability of a health entity to transfer a patient and instead oblige it to allow some of the process on site. In order to protect the conscience rights of those who own, operate and receive care in health care establishments, these subclauses 102(3), 103(3), 104(3), 105(3) and 106(3) should be deleted because they lay the legislative groundwork for future limitations on the conscience rights.