

## LAW AND JUSTICE COMMITTEE

### INQUIRY INTO THE PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

#### Supplementary questions: Dr. Eugene Moylan, Director, Liverpool Hospital Cancer Therapy Centre. Senior Staff Specialist, Medical Oncology, Liverpool Hospital

*Answers are to be returned to the Committee secretariat by 28 January 2022.*

1. In evidence provided to the inquiry hearing on 13th December, Dr. Danielle McMullen, President, Australian Medical Association (NSW) said:

“We would undertake that the requirement for two separate doctors to both consult with the patient about their reasoning, intent and illness and to discuss with them all options available to them for their care, including voluntary assisted dying... .” (Hansard, page 5)

In evidence to the inquiry hearing on the same day Dr. Cameron McLaren, appearing as a private individual from Victoria said:

“I underwent the training [Voluntary Assisted Dying training] for two reasons: I did not want a patient for whom I had cared throughout their journey with cancer to have to seek external providers that they chose to pursue this option [Voluntary Assisted Dying]; secondly having been educated in medicine with a strong focus on patient-centred care, I felt that my opinion... .” (Hansard, page 67)

In evidence to the inquiry hearing on the same day Dr. Greg Mewett, Palliative Care Physician, Grampians Regional Palliative Care Team, Ballarat Health Services, Victoria said:

“My final comments would be that I find this [Voluntary Assisted Dying], as a palliative care doctor, patient-centred care... .”

and

“Palliative care is a style of care which, near the end of life, VAD is one type of choice in that care – they are not mutually exclusive.” (Hansard, page 69)

In evidence to the inquiry hearing on the same day Associate Professor Charlie Corke, Acting Chair, Voluntary Assisted Dying Board, Victoria said: “I note that Dr. McLaren and Dr. Mewett both talked of patient-centred care. Really, the way in which we deliver health care can be considered as patient-centred care or medical-centred care or perhaps as legally-centred care or religious-centred care. There is a whole load of different ways we look at the way we deliver care. But, fundamentally, I think patients are wanting patient-centred care rather than any of those other options.” (Hansard, page 71)

Can you please comment on the implications for the professions of medicine and nursing and the overall medical, health and aged/residential care ecology of New South Wales by describing Voluntary Assisted Dying, as provided for in the *Voluntary Assisted Dying Bill 2021*, as “care” or “patient-centred care”?

#### Answer Q1:

Current patient-centred care is medical and nursing care delivered specifically designed to meet an individual’s unique physical, psychosocial and spiritual needs. It is based on the sound and long-held

principles of medical beneficence and “first do no harm”. The *Voluntary Assisted Dying Bill 2021 (VAD Bill)* radically changes the ecology of patient care by changing the role of health care professionals from that of “carer and healer” to that of an agent of assisted suicide. Health care professionals do not always give patients what they want eg prescriptions for sleeping tablets or drugs of addiction, medical certificates for days off work, certificates for disability pensions etc. We often advise patients against participating in activities that are detrimental for the individual and society in general eg stop smoking and refrain from excessive alcohol intake. This does not mean that we are not providing patient-centred care. It means that we are working within frameworks that are there not only for the benefit of the individual, but also for the greater societal good. Voluntary assisted dying may seem compassionate for the suffering individual, but is that truly “good” for the caring health professionals or society in general?

2. Clause 6 of the *Voluntary Assisted Dying Bill 2021* deals with the matter of decision-making capacity. Sub-clause 6(2) deals with the specific matter of patients, for particular purposes of the legislation, having “presumed capacity”. Can you please comment on the presumed capacity provisions (sub-clause 6(2)) of the Bill and in doing so, express your view about the appropriateness, or otherwise, of such provisions in a bill that provides for the establishment and operation of a Voluntary Assisted Dying procedure? Do the provisions pose any particular and specific threats and dangers to certain patient cohorts?

**Answer Q2:**

I do not believe that I am the best person to address this issue. It may be better addressed by a geriatrician with more extensive experience in the area of “capacity”. In Medical Oncology the issue most often arises in patients with brain tumours. The need for a comprehensive neuropsychological assessment to establish capacity is rarely needed due to availability of surrogate decision-makers. This would clearly need to change in the context of Voluntary Assisted Dying.

3. In evidence provided to the inquiry hearing on 8th December, Ms Penny Hackett, President, Dying With Dignity NSW said:

“The key feature of this law is choice. It is voluntary and no-one is compelled to be involved. Those who oppose VAD laws are not required to use them or to participate in the process.” (Hansard, page Can you please comment on what the actual meaning of the word “choice” is, as generally understood by the population at large and in the specific context of medico-health decision making?

**Answer Q3:**

“Choice” as understood by the population, is the ability to choose between two or more possibilities. In the context of health care, and the VAD Bill it would mean the ability to choose voluntary assisted dying over other continuing supportive and palliative care measures. As outlined above, in answer to question 2, we do not give patients everything they request. Another example would be a patient with end-stage terminal illness requesting cardiopulmonary resuscitation when such an intervention would be futile. It is our responsibility as health care providers to educate and counsel the patient and their carers as to why this would not be a good “choice”. Equally important, it is essential that health care providers do everything within their ability (and the ability of the health care community at large) to eliminate suffering that might trigger a request for voluntary assisted dying.

4. In regard to the evidence referred to above in question 3 and the issue of “choice”, what would be the real and actual implications for citizens who, while potentially meeting eligibility and other requirements of the Voluntary Assisted Dying Bill 2021, are not able to have provided to them high quality, readily available palliative care, particularly with respect to those residing in rural, regional and remote NSW?

**Answer Q4:**

There has been a progressive improvement in the health care provided to patients in remote, regional and rural communities over recent years with the advent of telehealth platforms. Although this may not be ideal in the palliative care and terminal illness context, the referral and consultative pathways that have been developed over recent years should provide a background upon which better palliative care services can be provided to disadvantaged communities.

5. In the Victorian *Voluntary Assisted Dying Act 2017* there is a strict prohibition on the subject of Voluntary Assisted Dying being initiated with a patient (clause 8). An equivalent strict prohibition provision is not contained in the New South Wales *Voluntary Assisted Dying Bill 2021*. If a piece of legislation is to proceed from the New South Wales Parliament regarding Voluntary Assisted Dying, should it include a strict prohibition provision similar to clause 8 of the Victorian *Voluntary Assisted Dying Act 2017*?

**Answer Q5:**

It is my opinion that a request for VAD and any ongoing discussion should only be initiated by the patient. Health care providers and carers should refrain from initiating such discussions as it poses a significant risk that conflicting messages regarding the intent of provision of care will be given to the patient (the patient should never be under the impression that care being provided for them is burdensome for either the health care staff or the community as a whole).

6. The Victorian *Voluntary Assisted Dying Act 2017* has, with respect to minimum requirements for co-ordinating medical practitioners and consulting medical practitioners, a requirement for the involvement of a medical specialist and an individual with relevant expertise and experience in the disease, illness or medical condition expected to cause the death of the person being assessed (clause 10). Equivalent provisions are not contained in the New South Wales *Voluntary Assisted Dying Bill 2021*. If a piece of legislation is to proceed from the New South Wales Parliament regarding Voluntary Assisted Dying, should it include provisions similar to clause 10 of the Victorian *Voluntary Assisted Dying Act 2017*?

**Answer Q6:**

I strongly support the minimum requirements for co-ordinating medical practitioners and consulting medical practitioners, necessitating involvement of a medical specialist and an individual with relevant expertise and experience in the disease, illness or medical condition expected to cause the death of the person being assessed.

7. Having regard to your written submission, oral evidence and specialised training, knowledge, practice and experience in medicine, what is your response, on the assumed facts as to what contemporary medicine can reasonably offer a person in the circumstances described below:

Opening Statement of Ms Abbey Egan. Wednesday, 8th December 2021 53-54

**Answer Q7.1:**

Care of the dying can be both difficult for staff and distressing for relatives and carers. The perceptions of carers in terms of patient suffering need to be acknowledged, but these perceptions may not be the lived experience of the terminally ill patient, particularly during the last few days of life. During the last days of life, the dying patient is often unaware of their surrounds, with altering phases of consciousness and unconsciousness. Loss of control cognitive function, bowels and bladder are not uncommon and are obviously distressing for those observing. The reality is that an unpleasant death is not predicable. Health professionals do everything they can to minimise distress and suffering for the dying patient as well as distress for the attending family, carers and friends. If we were to extrapolate the Voluntary assisted dying bill to avoid any unpleasantness around death for the entire population (and why wouldn't we want that), we would open the gates to wholesale euthanasia. Anyone who writes an advanced directive could request that they not be allowed to suffer and be assisted to die if the health professionals thought that was appropriate. Perhaps this is the hidden argument being proffered by those in favour of the VAD Bill.

Question asked by the Hon. Trevor Khan. Friday, 10th December 2021 31

**Answer Q7.2:**

“Venessa Pattullo chose to die alone without saying goodbye to her loved ones, and that was for a really, really good reason: She knew what the alternatives were. She did not want to die in a hospital; she knew what it would be like.” This is a presumption by the individual recounting the story about what was in the mind of Dr Pattullo in the moments before she took her own life. It assumes that Dr Pattullo took her own life at home because she knew what dying in a hospital would be like. I do not accept that we know why Dr Pattullo chose the timing and/or mode of her death. What was her state of mental health at the time? Why had she chosen a time to die when she was alone? The VAD Bill will not prevent such tragic events from occurring in the future. Suicide is always tragic. There is nothing in the VAD framework that might counter the decision that Dr Pattullo took in ending her own life alone, just facilitate it and legalise it for others to more readily avail themselves of this tragic end to life option.