**LAW AND JUSTICE COMMITTEE**

**INQUIRY INTO THE PROVISIONS OF THE VOLUNTARY ASSISTED DYING**

**BILL 2021**

Supplementary questions: Ms Julia Abrahams, Chief Legal Counsel, Catholic Healthcare

and member of Catholic Health Australia

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

**Question 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 andto discuss with them all options available to them for their care, includingvoluntary 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 thatmy 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 onetype 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 aslegally-centred care or religious-centred care. There is a whole load of different ways we look at the way we deliver care. But, fundamentally, Ithink 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"?

**Question 1 – ANSWER**

The Catholic health and aged care sectors do not see VAD as being part of "patient centred care".

When our patients or residents are dying, we strive to ensure that they do so in comfort and with dignity.

Consistent with this ethic of care, the Catholic health and aged sectors will not provide or administer a lethal substance to someone in our care. This position is consistent with the Hippocratic Oath and is shared by the Australian Medical Association and the World Medical Association – that is to do no harm

Voluntary assisted dying does not constitute health care.

In every health, aged care, and community facility, the people we care for and the people who provide that care know that our services do not offer VAD.

We know that people turn to our care because of our values, and because we commit to providing holistic and compassionate care to every person at each stage of their life's journey.

Relieving suffering is a primary concern of good medical, clinical psychosocial and pastoral practice – as is improving the wellbeing of every person with a life-threatening illness and supporting their families in the process.

We believe the best way for us to demonstrate our compassion and "patient centred care" is not to expedite someone's death, but for our professional staff to provide high quality palliative care that relieves pain, alleviates stress and cares for the individual to their natural end. This approach to care is central to Catholic health providers and employees recognising an individual's inherent worth and dignity as a human person regardless of their current health status, age, capabilities, or characteristics.

They are entitled to the same care as every other human being who is experiencing mental ill health, social isolation, the sense of being a burden, loss of meaning and loneliness.

No one should need to take their own life because of these things.

Catholic Health Australia and its members are concerned that the legalisation of voluntary assisted dying in New South Wales, while ostensibly benefiting a small percentage of people—perhaps one in 200 of those who die—who want the option of euthanasia available to them, it nevertheless poses a greater unintended but foreseeable risk to people living with significant vulnerability.

No safeguard, legal or otherwise, could adequately protect the vast majority of the vulnerable from harm. The risk of coercion will always be present.

**Question 2**

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

Clause 9 (and related provisions) – Registered health practitioners may refuseto 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?

**Question 2 - ANSWER**

This Bill exposes care providers, their staff, visitors, volunteers, and other patients/residents at aged care facilities to significant risk.

In the case of aged care facilities which do not have the supports available in healthcare facilities, where residents sometimes reside in shared accommodation, and where residents with varying levels of dementia wander, the risks are particularly acute.

These include but are not limited to:

- **Safety risks around storage of the lethal substance -** the capability of aged care providers to store for substances is quite different to hospitals and healthcare facilities; there are no pharmacists or GPs in aged care facilities, and the bulk of the workforce is comprised of individuals at the levels of Certificate III and IV. They do not have the knowledge or skill to deal with such substances.
- **Safety risks of wandering residents coming upon the lethal substance by accident when the substance is stored in the resident's room;** - a significant proportion of residents in aged care facilities have varying degrees of cognitive impairment. Federal and State laws, properly and severely, constrain the ability of the provider to restrain these residents and from time to time they enter other resident's rooms and even go through the possessions of other residents. There is a real possibility that such a resident may encounter the lethal substance.
- **Risk of emotional distress** - aged care facilities provide long term (as opposed to episodic) care: they are the residents' home, and the residents and staff are often like family. Many of these residents and staff form very strong bonds and the impact of each death can be very great including evoking great sadness, depression, anxiety, and despair. The cumulative effect of these deaths on staff and residents, of the loss of closely connected loved ones, month after month, cannot be over-estimated. It is bad enough when a death occurs of natural causes, but the impact of a death by lethal injection which would compound grief, loss and despair with guilt and shame could, for many, be intolerable.
- **Risk of spiritual distress** – many residents, staff and volunteers choose a Catholic or Christian aged care home precisely because of the ethos and ethic of these homes – this includes their objection to voluntary assistance dying. Many residents together with their loved ones, choose Catholic or Christian facilities based on the protection and security this culture of care provides against the pressures and exposure to assisted dying. In their last days, these residents, and their families, want to be surrounded by the ethos and practices that support their beliefs and

customs of a lifetime, prepare them for the death they wish to experience and hope to achieve. For these residents, families and staff, the provision of death by lethal injection within the facility, would be disruptive, distressing, and repugnant. Allowing VAD into every aged care home would deny such residents and families the right to choose the institutional culture of care they wish to be surrounded by the death they wish to experience and deny such staff the right to work in an environment that aligns with their values.

The Bill claims to offer choice in end-of-life matters, but if it passes it won't protect the choice of people in aged care facilities who don't want anything to do with assisted dying.

Catholic aged care facilities provide a safe place for those in the community who do not wish to be involved in assisted dying.

The Bill would dismantle this protection by allowing doctors to access any aged care service and use its facilities for the purpose of assisted dying. A doctor can do this without informing the institution involved.

This goes against the duty of care we owe our residents at aged care facilities. It creates an unacceptable level of risk to other residents, as well as the safety and wellbeing of our employees.

In Catholic aged care facilities, the Bill could expose workers in our facilities to handling lethal drugs and the euthanising of vulnerable people with whom they have a caring relationship.

It could also cause severe distress by exposing other residents in shared accommodation to assisted dying taking place.

In a climate post Royal Commission into Aged Care, which exposed challenges facing the elderly, this is an unacceptable risk.

**Question 3**

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 toparticipate 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?

**Question 3 – ANSWER**

Catholic Health Australia members continue to oppose legislation for all the reasons that we have outlined in our detailed submissions and through testimony given to the Committee's hearings. Catholic Health Australia's members are willing to engage with any legislator who would like to talk to us about how to improve what is a deeply flawed Bill.