Supplementary question 1: Professor David A. Jones, Anscombe Bioethics Centre

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"?

Voluntary Assisted Dying as provided in the Voluntary Assisted Dying Bill 2021 refers to the self-administering or administering by another of a substance for the purposes of causing a patient's death. To equate this with 'care' or 'patient-centred care' is to imply that intentionally hastening death is beneficial for the patient and the patient's choice to seek death is one that should be condoned or affirmed.

This fundamentally changes the character of healthcare and this change affects everyone who receives or participates in healthcare. This change is a departure from the Hippocratic Oath and the received understanding of end of life care or palliative care more generally.

If intentional hastening of death constitutes beneficial care then it is not clear why it should not be suggested to a patient, at least as an option to consider. The prohibition of healthcare professions from initiating discussions of VAD makes no sense if VAD is beneficial care.

Similarly if VAD constitutes 'patient-centred care' then professionals who do not provide it are depriving patients of access to care. The provision of care is an imperative of healthcare and those unwilling to provide it would seem to have no place in healthcare.

Similarly, if VAD constitutes beneficial care for some patients it is not clear why intentional hastening of death should not be provided to people who are not in a position to ask for it. Care is not restricted to competent patients! Pain relief is given to people who are not able to request it but are in distress. If the intentional hastening of death is justified as a way to alleviate distress, why should it not also be provided to someone in evident distress and whose distress would be eliminated by hastening death?

There are provisions in he Voluntary Assisted Dying Bill 2021 which prevent healthcare professionals from suggesting or encouraging VAD, which protect the conscience rights of healthcare professionals opposed to VAD and that require overt consent before the VAD substance is administered. However, if VAD constitutes 'patient-centred care' then these provisions are at best unnecessary and at worst an obstacle to care. They function as a political means to smooth the passage of the Bill, but if the practice is established and is regarded as 'patient-centred care' these provisions will be regarded as unduly restrictive and will not endure. This is evident from other jurisdictions, especially Canada.

Finally, if intentional ending of life by a healthcare professional constitutes 'care' then it is not clear why it requires any special legal provision. The use of analgesia or sedation is legitimate for reasons of symptom control even if they hasten death (which in fact they do not typically do). This does not require any special legal provision because these practices are well-established elements of healthcare, as has been established by case law. If intentional ending of life constitutes 'care' then acts not considered in the VAD Bill, but which have the same effect, will also constitute care. This is what has happened in Belgium with the use of 'palliative sedation' to bring about death without the requirements of law.

Supplementary question 2: Professor David A. Jones, Anscombe Bioethics Centre

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?

A theme throughout the debate around the proposed Bill is that this would increase patient 'choice' in relation to end-of-life care. At one level this is unarguably true. Voluntary euthanasia and physician-assisted suicide are not currently available as organised practices within New South Wales. If the VAD Bill 2021 passes into law, then these would be extra options. There may be other ways to increase choice at the end of life (for example more support for dying at home) but these will not satisfy those who seek the particular choice of a 'voluntary assisted death'. Nevertheless, both medicine and law rightly limit choice when doing so serves the Common Good, for example, limiting access to antibiotics or regulations restricting movement and social contact so as to prevent transmission of COVID-19. The question is whether creating or restricting this or that choice is helpful or harmful for society as a whole. All laws constrain our choices to a greater or lesser extent.

Furthermore, laws of this kind have a very broad impact on society and on the practice of medicine. These changes in turn frame the choices that people have and the rational justifications they are able to give or are required to give. An important example is the way that the availability of physician-assisted suicide forces people to have to justify why the wish to live rather than save others the burden and expense of their care. They can avoid answering that question but the law invites the question and they do not have a choice about being placed in that situation where hastening their death is now a legal option. Giving an extra choice can thus also constrain autonomy in a potentially lethal way (see X. Symons & R. Chu, '"Alive by default": An exploration of Velleman's unfair burdens argument against state sanctioned euthanasia.' *Bioethics* 34.3 (2020): 288-294).

No choice exists in a vacuum and the provision of a choice to die for some may weaken or undermine the choice to live for others. Overall, there is very strong evidence that passing such laws leads to and increase in avoidable premature deaths and there is no evidence that it helps reduce rates of non-assisted suicide (See David A. Jones and David Paton 'How does legalization of physician assisted suicide affect rates of suicide?' *Southern Medical Journal* (2015) 108.10: 599-604).

Supplementary question 3: Professor David A. Jones, Anscombe Bioethics Centre

In regard to 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?

This question shows how choice is always contextual and the choice to seek intentional hastening of death is one that depends on what alternatives are available.

Even if palliative care is available, patients may be aware, or may be made aware, of the cost of their continued care and the cost saving by choosing VAD. They may consider the provision of palliative care to be a burden on carers or professionals, especially if great efforts have to be made to ensure delivery of services to remote areas. They may consider that healthcare would be better directed to people who have more of their life ahead of them, who are more 'worthy of life'. They may be subject to elder abuse of a physical or psychological kind which weakens their will to live. Even if palliative care is provided alongside the option of VAD, the internal and external barriers to accessing palliative care may be greater than the barriers to receiving VAD. It is indeed presented precisely as an 'easy way out', whether or not this is in fact true in practice.

Making an option available changes everything for everyone (see comments in relation to supplementary question 2). It requires people to justify (to others or to themselves) why they should receive ongoing care when a far less costly alternative is readily available.