

**Submission  
No 12**

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

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## Submission to the NSW Parliamentary Inquiry into Voluntary Assisted Dying

Julian Gardner AM

12 November 2021

I make this submission with an intimate knowledge of the development of the VAD legislation in Victoria. I was a member of the Ministerial Advisory Panel that undertook extensive research and consultation in preparing recommendations to government that amounted to drafting instructions for the legislation. Following passage of the Act there was an implementation period of 18 months during which I was the Chair of the VAD Implementation Taskforce.

Previously in my career I had been Victoria's Public Advocate, a position that is the guardian of last resort. In that capacity was concerned with the protection of the rights and interests of people with cognitive disabilities. In addition, I gained insights into end-of-life care as a consequence of having to make critical end-of-life decisions.

I did not come to my role on the Ministerial Advisory Panel as an advocate for voluntary assisted dying. My primary concerns by which I assessed the proposals were:

- Human rights. The promotion of human rights and most notably that of autonomy.
- Safety. The protection of those unable to adequately protect themselves and who were therefore at risk of abuse.
- Compassion. The promotion of a more compassionate society and the reduction of suffering.

VAD legislation does raise deeply held objections based on ethical considerations and matters of faith. While I do not share those views, I acknowledge and respect them. I do not propose in this submission to address those matters but rather to address the objections that raised practical or operational matters and to comments on a couple of other matters.

### **“Practical” objections**

During the consultations of both the Ministerial Advisory Panel and the Implementation Taskforce I heard numerous objections raised by opponents to the legislation and concerns raised by those who wished to ensure the safety of the operation of VAD.

I have no doubt that you have heard similar objections and concerns. They include, by way of some examples:

the risk of elder abuse

the risk of coercion

the risk of people not taking the medication properly and not dying quickly

the risk to the community of the medication unlawfully leaving the custody of the patient

the risk of family members or others ingesting the medication

the risk of discouraging people from accessing palliative care

the risk that palliative care services would be de-valued and under-resourced.

It is important that these risks, and others like them, be considered not just hypothetically, but against available evidence.

This latest report from the Victorian VAD Review Board, which monitors the safe and lawful operation of VAD law, covers just over two years of operation in Victoria.

It contains no evidence of any such risks being realised. There were no scandals, no evidence of coercion or elder abuse, no misuse of medication and no cases of professional misconduct.

The evidence is that, with appropriate safeguards, VAD operates safely.

### **Equity of access.**

It is recognised that people living in regional and remote areas do not enjoy the same level of access to high-quality health services as those in capital cities. Therefore, any features of VAD legislation that exacerbate that problem should be avoided. In Victoria there is a requirement that one of the two assessing medical practitioners must be an experienced specialist in the medical condition from which the person is suffering. This has caused difficulties for some patients living outside Melbourne in accessing specialists, especially in neurology. I therefore support the proposed provisions in cl 18 that are broader than those in Victoria. While ensuring that assessments are made by experienced and qualified medical practitioners, they do avoid exacerbating problems of equity of access.

### **Access to medical advice about options for treatment.**

For a person to be able to make an informed decision about medical treatment they must be fully informed about their options. In Victoria a medical practitioner is prohibited from initiating a discussion about VAD and therefore including it as an option.

While seen as a safeguard, this prohibition conflicts with the duty of a medical practitioner to put to a patient all available options so that they may make an informed decision about their medical treatment. In addition, it creates a risk that a person may make a treatment decision without being fully informed of their options. I therefore support the proposal in cl 10 of the Bill.

### **Palliative care**

As mentioned above, some objections to VAD were based on concerns that people would be inhibited from accessing palliative care. It must be stressed that VAD is not an alternative to palliative care. It is simply one more option for end-of-life care.

Evidence from the USA is that those accessing VAD are two times more likely to also access palliative care than the population at large. The evidence from two years of operations in Victoria is that 82% of those who accessed VAD were currently receiving palliative care. On this evidence there is no basis for the concerns raised about inhibiting access to palliative care.

The high level of access may, in part, be explained by the provisions contained in Victoria's VAD Act (replicated in the NSW Bill) that impose a legal requirement on doctors to explain palliative care options to an applicant for VAD. No such legal obligation exists for other patients.