Submission
No 30

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Organisation: Catholic Women's League Australia – New South Wales Inc

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It is with pleasure that Catholic Women's League Australia – New South Wales Inc. (CWLA-NSW) provides a submission to the Inquiry into the Provisions of the *Voluntary Assisted Dying Bill 2021*.

CWLA-NSW's primary submission is that the *Voluntary Assisted Dying Bill 2021* (NSW) should be voted down and not allowed to pass into law.

About the Catholic Women's League in New South Wales
CWLA-NSW has been present in New South Wales for more than a century, beginning in 1913 with the Catholic Women's Association. We have approximately 1650 active members in the eight Catholic dioceses in New South Wales. Our organisation fosters the spiritual, cultural, intellectual, and social development of women and promotes the role of lay women in the mission of the Church. This submission is made on behalf of CWLA-NSW, a member organisation of the Catholic Women's League Australia Inc. (CWLA), the national peak body representing the League's six-member organisations located throughout Australia. In addition to its long-standing presence in Australia, CWLA has a consultative status with the Economic and Social Council of the United Nations and is also a member of the World Union of Catholic Women's Organisations, which represents one million women in 60 countries.

The *Voluntary Assisted Dying Bill 2021* reduces human life to its physical dimension. While the science and medicine of palliative care and our understanding of the human psyche and spirit are growing, this Bill is moving in the opposite direction. It diminishes a person to diagnostic and prognostic categories. It supposes that dignity is part of death by a purchased pharmacy product.

We might think here in New South Wales (NSW), where we are the only state in Australia not to have legalised it, that euthanasia is a reality practically everywhere in the developed world. That is not so. Euthanasia is legal in only ten of the 195 countries recognized by the UN: Belgium, Canada, Colombia, Luxembourg, the Netherlands, New Zealand, Spain, Switzerland, a few states in the US and all states in Australia except NSW. The immense majority of the countries of the world do not have it.[1]

This tells us something. Do we really need to legalise assisted suicide, as it is called in the laws of some countries? We deplore suicide and yet we want to legalise it for certain suffering people. In so doing we are making a distinction between people whose lives are "worth living", who therefore should not commit suicide, and others whose lives are "not worth living", who therefore should be able to commit suicide.[2] On that basis, the fundamental principle of a democracy that all are equal before the law is not respected. Incidentally, it was in part for that reason that the British House of Lords rejected the legalisation of euthanasia in the 1990s.[3]

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[1] Flader, John (Fr). 'Euthanasia and compassion', *The Catholic Weekly*, 7 November 2021, Page 23
[2] Flader, p. 23
[3] Flader, p. 23

All lives are worth living. Suffering is part and parcel of the life of man on earth. We all have it in varying degrees and at different times. As we see in the list of countries where euthanasia is legal, there is not one African or Asian country.[4] We must remember Pope St John Paul II's observation in his encyclical *Evangelium Vitae*:

"Here we are faced with one of the more alarming symptoms of the 'culture of death', which is advancing in all prosperous societies, marked by an attitude of excessive preoccupation with efficiency and which sees the growing number of elderly and disabled people as intolerable and too burdensome".[5]

What suffering people most want is good care from medical staff, as well as compassion, love and the presence of their loved ones, not a quick end to their suffering.[6] As St John Paul II put it:

"True 'compassion' leads to sharing another's pain; it does not kill the person whose suffering we cannot bear".[7]

Euthanasia means "good death" however definitions often change over time and in this case, euthanasia is often described as the practice of intentionally ending life to relieve pain and suffering. Different countries have different euthanasia laws. The British House of Lords Select Committee on Medical Ethics defines euthanasia as "a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering". In the Netherlands and Belgium, euthanasia is understood as "termination of life by a doctor at the request of a patient". The Dutch law, however, does not use the term 'euthanasia' but includes the concept under the broader definition of "assisted suicide and termination of life on request".

There is no doubt that fear – fear of dying, fear of pain, fear of the unknown, fear of loss of independence or autonomy, fear of one's family's distress or even fear of fear itself - can be debilitating. Fear is a strong and usually unpleasant emotion. However, fear can be rational or irrational and cause difficulty in decision making as may occur during one's contemplation of a possible burdensome future.

Who are we who oppose the concept of euthanasia or voluntary assisted dying (VAD) to discount the feelings of persons in such situations? What do we know about dying? What do we know about the process of dying? Well, we know this - some from personal experience or working in some capacity in the health care system. We know that everyone deserves the best of end-of-life care, that encompasses physical, emotional, and spiritual aspects of compassion and care.

Currently, most patients die in hospital – an area foreign to many of us. It behoves those involved in end-of-life care ensure that decision making is based on truthful and effectively explained options for care – that may mean for and/or against active killing. Increasingly euthanasia/ VAD is becoming integrated into the practice of medicine. All health care should be patient-centred and, where possible, individualised.

NSW Premier Dominic Perrottet, has conceded his government had failed to adequately fund palliative care, promising to fix the system rather than allow VAD. The option of effective and adequate palliative care should be discussed when helping a person with their options.
This is not always so. Those members of our community at most risk of not being able to access effective and compassionate Palliation, due frequently to a lack of funding, are those residents

[4] Flader, p. 23
[5] Pope John Paul II, *Evangelium Vitae*, 25 March 1995, page 64.
[6] Flader, p. 23
[7] Pope John Paul II, *Evangelium Vitae*, 25 March 1995, page 66.

living in rural and remote areas in NSW. Catholic Health Australia (CHA) has consistently called for increased funding for the palliative care sector, to provide people with genuine choice in their end-of-life care.

It would be extraordinary if the NSW Parliament committed itself to the principle of equal access to euthanasia and assisted suicide so that people suffering from a terminal illness might be able to end their lives without equally committing itself to the principle of equal access to the necessary healthcare to assist them to live in comfort
and die with dignity.

Cook has noted that, "Modern man is in love with anything that promises pleasure and freedom from pain, and that's how health-care killing is being sold. A next logical next step is euphoria on demand. Those who can't afford the full package will be dispatched by a government hit man, but the well-off will have a party of it. Pharmaceutical companies will compete to provide the best trips. Televised celebrity death extravaganzas. Luxury suicide vacations." [8]

The Archbishop of Canterbury, Justin Welby, recently told the BBC: "What we want is assisted living, not assisted dying. … Sadly, people make mistakes in their diagnosis. It leaves people open to very, very intangible forms of coercion and pressure. I have sat in places where I have known that people were having pressure put on them in ways that would never come out."[9]

What about the notion of a "slippery slope"? The JAMA Internal Medicine hosted a fiery debate about Dutch euthanasia recently. Geriatrician Diane Meier, of the Icahn School of Medicine, New York, responded feistily to critics of an editorial which she had written in December, headlined "The Treatment of Patients with Unbearable Suffering—The Slippery Slope Is Real." Two teams of Dutch physicians responded with reassurances that "all of these Dutch cases of physician-assisted suicide are characterised by a vital patient-physician relationship and that all these requests are voluntary and well considered" and that "instances of physician-assisted suicide always follow the letter of the law and never involve family, financial, or other pressures." However, "These contentions are "based on hope, not on research," says Meier. [10]

Ultimately, how are doctors to decide which deaths should be sanctioned, and which we should strenuously try to prevent? If psychological distress, chronic pain, reduced capacity, and dependence on others are increasingly seen as legitimate reasons to end a life, what is the subtext for members of our community who face these challenges every day, and find ways to build a meaningful life out of them?

Most VAD laws require that, in the judgment of two medical specialists, the person must have less than six months, or sometimes a year, to live. We all know that the judgment in many cases is no more than guesswork.[11] There are a good number of terminally ill people who were given only months to live and who were still alive years later.

CWLA-NSW identifies the following specific issues in the *Voluntary Assisted Dying Bill 2021*:

a) In Part 3. The Patient's Eligibility Assessment

No provision or recognition is made for the impairment of depression. It is recognised that depression impacts cognition and severe depression impairs decision-making capacity. No

[8] Cook, Michael., *Bioedge*, 13 November 2021
[9] Archbishop of Canterbury, Justin Welby , interviewed on BBC. By Gavin Cordon, 22 October 2021
[10] Meire, D., 'The Treatment of Patients with Unbearable Suffering – The Slippery Slope is Real', *JAMA Intern Med*, February 2021, pp 160-161.
[11] Flader, John (Fr). 'Euthanasia and the bottom line', *The Catholic Weekly*, 31 October 2021, Page 31

consideration is proffered nor is the impact to be assessed of a person's mental health in seeking to end their life. Decisions made by a person with poor mental health are unlikely to be the same as decisions made by a person with sound mental health. Depression may be a consequence of severe or chronic health problems and deserves adequate assessment and treatment before vital irreversible decisions may be made[12]. Given that doctors authorising the person's euthanasia are not required to have examined the patient, this is reckless care. Failure to assess mental health and the contribution of depression to the patient's wellbeing and decisions is a further neglect of mental health significance and priorities.

Neglected mental health has been a particular feature of isolation caused by ill health. This has been exemplified and highlighted in the pandemic situation. It should therefore be a foremost consideration in decision making, especially in crisis decision making which may affect euthanasia expeditiously within five days. If indeed depression therapy were to be considered it takes several weeks to begin to have a therapeutic effect.

Irreversible and incurable illness is *only implied* as the only access to euthanasia. This blurs the interpretation of 'incurable and irreversible'. The *Voluntary Assisted Dying Bill 2021* can be interpreted to include death which would be inevitable without treatment. It might not be inevitable if it were treated. A disease might be called 'incurable' even if it is quite treatable, such as in the case of diabetes. This Bill would include any person with an illness who would die in six months without treatment. If the person considers the treatment (eg insulin) too onerous, they would qualify for euthanasia. Similarly, if the patient finds it very difficult to access the treatment, then the disease may be irreversible. Health Insurers in Nevada have utilised this and refused to pay for some treatments but agreed to pay for euthanasia**.**

b) In Part 3 Division 1. Concerning Eligibility for Medical Practitioners
Doctors who seek to take part in the 'actions' of euthanasia as the initial practitioner or the consultant may have no specialisation or experience in the person's particular medical conditions. They may not have met or examined the patient, and they will not therefore have the capacity to make determinations from the usual history and clinical findings considered vital to competent medical therapeutics. This relegates end of life appraisals and decisions to tick box medicine. The depth of the therapeutic relationship is missing and its importance dismissed, at this most crucial time for valid decision-making.

c) In Part 9 Protection from Liability
The Bill provides for poor and loose regulations. In a context that may be attended by coercion, depression, despair, conflicts of interests and crisis decision making, legislation must be designed to be upheld in its safeguards. This legislation, by contrast, makes provision for departure from its own due process. The Bill excuses and exonerates in advance those who do not maintain its protective standards. When the law has not been followed and there are omissions in the doctor's procedural duty of care to the patient, the doctor will only be required to have assumed the correct steps were followed. The doctor does not therefore need to have made sure all the correct safeguards have been adhered to. This provides for, and indeed creates, an unsure uncensured environment where subjective presumptions of 'goodwill' and 'reasonable care' will suffice as standards. If it is anticipated that the safeguards and standards of the Bill will be so neglected, then the safeguards and the Bill itself are of insufficient quality to implement. There exists already a presumption the standards of the Bill will not be carefully and reliably upheld.

[12] Mendz, GL, Kissane, DW. 'Agency Autonomy and Euthanasia', *Journal of Law, Medicine and Ethics,* 6 October 2020.

The issue of insurance needs to be addressed. VAD legislation selectively hurts the poor. Those with financial means usually have health insurance which may pay for their treatment, or they can afford to pay for it themselves. Hence they will be more likely to draw on those resources in order to live longer, and sometimes they will recover completely. But those with fewer means cannot afford to do this. The cheapest, and sometimes the only, alternative is to choose to die.[13]

We also have to consider the fact that insurance companies will refuse to pay for expensive treatment. If VAD is legalised and if insurance companies refuse to pay for expensive treatment, there will be many people who will choose to die prematurely and unnecessarily, when they might have lived for many more years.

CWLA-NSW believes that the Bill could allow for "elder abuse". The financial pressure to choose death rather than life not only comes from insurance companies but also from family members who will inherit the estate of the dying person. The longer that person lives the more expensive will be their medical costs. Family members will see their inheritance reduced and could suggest to the relevant relative "out of compassion" to end their suffering by choosing VAD.

It should be noted that CWLA-NSW is in agreement with and fully supports the submission by the Catholic Bishops of New South Wales and the Bishops of the Australasian-Middle East Christian Apostolic Churches concerning this Bill.

Euthanasia / VAD is an alienating and sometimes hostile topic, and different interpretations of its meaning, practice, and morality abound. There can be no doubt that persons on either side of this discussion/argument are genuine in their beliefs. It is urgent therefore that our elected Parliamentarians carefully consider their responses to the *Voluntary Assisted Dying Bill 2021*.

CWLA- NSW's State Bioethics Convenor was invited to make a presentation to NSW Parliamentarians on Wednesday, 17 November 2021. This presentation is hereto attached.

Conclusion
CWLA-NSW is grateful for the opportunity to provide this submission for your consideration. CWLA-NSW does NOT support the *Voluntary Assisted Dying Bill 2021*.

Michelle Pedersen

President

[13] Flader, Page 31