Submission
No 42

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Organisation: Anglican Church Diocese of Sydney

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Anglican Church Diocese of Sydney

22 November 2021

Submission to the Standing Committee on Law and Justice Inquiry into the Provisions of the Voluntary Assisted Dying Bill 2021

Who are we?

1. This submission is on behalf of Anglican Church Diocese of Sydney (the Diocese). The Diocese is one of 23 dioceses that comprise the Anglican Church of Australia. The Diocese is an unincorporated voluntary association comprising 270 parishes, Anglican schools, Anglicare Sydney (a large social welfare institution, which includes aged care), Anglican Youthworks and Anglican Aid (which focuses on overseas aid and development). The Diocese, through its various component bodies and through its congregational life, makes a rich contribution to the social capital of our State, through programs involving social welfare, education, health and aged care, overseas aid, youth work and not least the proclamation of the Christian message of hope for all people.

2. Anglicare Sydney has submitted a separate submission, to be read in parallel with this submission. The submission from Anglicare highlights the specific concerns around the intersection of this Bill and its operations, especially the provision of life affirming Residential Aged Care.

3. We welcome the opportunity to make this submission and we give consent for this submission to be published. Our contact details are as follows.
   Full Name: The Right Reverend Dr Michael Stead

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Introduction

4. We understand that the Voluntary Assisted Dying Bill 2021 is supported by individuals with deeply personal and moving stories. We agree that it is extremely important to hear from those suffering from terminal illness, and to ensure that they are well supported. Our opposition to the bill is informed by a two thousand year tradition of caring for the sick and suffering. We are neither immune to nor unaware of the personal dimensions of this complex issue. However, our opposition to the legislation is based on our convictions about what is best for society as a whole and the most vulnerable in particular. When it comes to matters of life and death, a comprehensive review of all evidence, especially the impacts of similar legislation introduced in other jurisdictions, is crucial.

5. The legalisation of assisted dying will lead to a fundamental shift away from the protection of innocent human life, a cornerstone value of Australian society and our legal system.

6. The Anglican Church of Australia holds that "life is a gift from God not to be taken, and is therefore not subject to matters such as freedom of individual choice".[1] This position has not changed. Many people of faith in NSW, both Christian and from other faith traditions, oppose this legislation as contrary to their beliefs. The Sydney Diocese of the Anglican Church has consistently and publicly opposed moves to legalise euthanasia in NSW.[2] We oppose this present Bill in principle.

7. Voluntary Assisted Dying laws involve doctors killing patients or assisting patients to kill themselves by supplying them with poison. Christian opposition to voluntary assisted dying is grounded in the knowledge that all human life is precious in God's sight, that God alone determines the limits of human life, and that the Bible prohibits the purposeful killing of innocent people. Compassion should motivate us to devote ourselves to care for others to the very end of their lives, rather than intervening to end their lives. It is out of compassion for the community as a whole—particularly the vulnerable—that we oppose Voluntary Assisted Dying.

8. Respect for human life is not just a religious value, but a foundational value for all societies. The value and dignity of each person is not diminished by age, disease, dependence or disability, nor is it based on their capacity to contribute to society. Those whose lives end in infirmity and incapacity are no less 'dying with dignity'. Voluntary Assisted Dying laws teach the community that some lives are not worth living, which can reduce our tolerance for the sick, dependent and disabled and thereby diminish their view of themselves.

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[1] Anglican Church of Australia, Synod Proceedings, 1995

[2] Anglican Church Diocese of Sydney, Synod Proceedings 2010, Resolution 38/10: Euthanasia.

9. Voluntary Assisted Dying will fundamentally undermine the trust of the doctor-patient relationship and the 'do no harm' principle, on which the medical profession is based. Provision of lethal medication is not health care. It is contrary to the goals of medicine and medical ethics. The Australian Medical Association has been consistent in its opposition to the legalisation of euthanasia and assisted suicide. Its official position is that "doctors should not be involved in interventions that have as their primary intention the ending of a person's life."

10. The euphemism 'voluntary assisted dying' masks the reality of the actions under consideration, which is either the killing of a patient by a doctor (traditionally 'euthanasia') or a patient's killing of themselves using means provided by a doctor (traditionally 'physician assisted suicide'). Whatever it is called, the practice sends mixed messages about suicide prevention. One example of the impact this can have is the 34% rise in non-assisted suicides[3] in the Netherlands (the first country to legalise euthanasia) from 2007 to 2019. A similar response was seen in US states where physician assisted suicide has been legalised. This raises the likelihood that the legalisation of assisted suicide will send a message to the public that suicide is a legitimate solution for suffering, exacerbating the current crisis of suicide in Australia. The "social contagion" effect of suicides is well-documented, making the timing of this bill especially bad when so many Australians—especially young adults—are suffering from mental illnesses as a result of the recent lockdowns, and are therefore more vulnerable to this effect.

11. Once legalised, the rate of assisted suicide and euthanasia continues to increase over time.[4] In the Netherlands, euthanasia rates more than doubled from 2002 to 2019.[5] The overseas experience shows that more and more individuals are taking up the opportunity to request assisted dying as the process becomes 'normalised' through familiarity.

12. In several overseas jurisdictions with legal euthanasia, changes to ideology and practice have occurred over time. Notably, a widening of the criteria for inclusion has exposed vulnerable people to abuse, including children and those suffering from mental illness and other non-terminal illnesses.

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[3] Boer T. "Legalising assisted dying can actually increase suicides", *MercatorNet*, 17 Sep 2020, [online article: accessed 28 Oct 2021], https://mercatornet.com/legalising-assisted-dying-can-actually-increase-suicides/66597/.

[4] Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW, Cohen J. Attitudes and practices of euthanasia and physician-assisted suicide in the United States, Canada, and Europe. *JAMA*. 2016; 316(1):79-90. [article online PubMed: accessed 15 Nov 2021], https://www.ncbi.nlm.nih.gov/pubmed/27380345.

[5] "A critical look at the rising euthanasia rates in the Netherlands," Healthcare in Europe, 15 Jan 2021. [online article: accessed 28 Oct 2021], https://healthcare-in-europe.com/en/news/a-critical-look-at-the-rising-euthanasia-rates-in-the-netherlands.html.

13. Assisted dying advocates deny the 'slippery slope'. Yet overseas experience reveals continued pressure to broaden eligibility criteria for euthanasia. In Belgium, in the space of less than 15 years, the application of euthanasia laws has greatly expanded. What started as an intention to relieve physical suffering in terminally ill adults now includes those who are lonely and 'tired of life'. Euthanasia for psychiatric patients was rare in early years of the law, but patients complained that they were being unfairly stigmatised and that their psychological suffering was 'unbearable'. Although most of the Belgian patients who are granted euthanasia have cancer, people have also been euthanised for autism, paralysis, blindness, deafness and manic depression. In 2016, 13% of Belgians who were euthanised did not have a terminal condition, and roughly 3% suffered from psychiatric disorders. Child euthanasia is also now legal in Belgium, with three children being euthanised between 2016 and 2017, two of them under the age of 12. [6]

14. We note that, by its terms of reference, this inquiry is into the provisions of the Voluntary Assisted Dying Bill 2021. As such, the focus of this submission is to highlight the deficiencies of the current legislation and propose amendments. It should be noted that, even with these amendments, we **do not** endorse the practice of euthanasia or assisted suicide or condone its legalisation **in any form**.

Deficits in the Current Legislation

15. The current Bill is defective for three reasons. Firstly, because it prioritises physician-assisted suicide over palliative care. Secondly, because it lacks essential safeguards, a number of which were present in the Bill rejected by the NSW Parliament in 2017. Thirdly, because it forces religious residential aged care facilities to support practices which are contrary to the doctrines, tenets and beliefs of the facilities.

(i) Prioritising Voluntary Assisted Dying Over Palliative Care

16. Voluntary Assisted Dying is promoted as the answer for those with intolerable suffering, but with access to suitable palliative care, any cases of intolerable suffering will be exceedingly rare. Palliative care is a more effective and just way of addressing suffering in dying, and should be available for all people in New South Wales who want and need it. Voluntary Assisted Dying is a poor alternative to the proper funding of best-practice palliative care and it should not be considered by Parliament until such inequity in access is addressed.

17. A change in the law is unnecessary to relieve the suffering of the terminally ill. Palliative care is effective in the vast majority of cases to relieve or manage pain and suffering amongst the terminally ill. When regular pain medication proves ineffective

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[6] Aviv R. "The Death Treatment: when should people with a non-terminal illness be helped to die?", *The New Yorker*, 22 June 2015. [online article: accessed 15 Nov 2021], https://www.newyorker.com/magazine/2015/06/22/the-death-treatment.

in patients with severe pain, deep sedation can be used to control symptoms ethically and legally. There is widespread misinformation about the use of opioids and sedatives. Rather than killing the terminally ill, there is evidence to suggest that therapeutic use of opioids and sedatives may prolong life.[7] Metabolic changes in terminal illness and reduced appetite have often been interpreted by observers as doctors 'starving' elderly or terminally ill patients in order to hasten death. This misunderstanding is seen by statements, such as those on the public record, by politicians who have likened dying relatives to 'starving Ethiopian refugees'.[8]

18. Current Australian data shows that only approximately 2% of patients in palliative care units experience pain at the end of life.[9] This seems to suggest that it is not untreatable pain and suffering that motivates people to request euthanasia, but a regrettable lack of awareness about available options. Patients should not be encouraged to request assisted dying as an escape from treatable pain and suffering, especially if they are unaware of the effectiveness of that treatment.

19. Evidence shows that the wish to hasten death reduces in patients who receive good palliative care. "When adequate palliative care, symptom control and psychosocial support is available and accessible, only a tiny minority of those accessing such support express a preference for euthanasia." [10]

20. Good palliative care is available in Australia, although currently it is not sufficiently accessible to all who would benefit from it. At present, only about half the people in NSW who would benefit from palliative care can access it. NSW has 1.2 full-time equivalent (FTE) palliative medicine physicians per 100,000 people.[11]. This is just over half of the benchmark of 2.0 FTE palliative medicine physicians per 100,000 population recommended by Palliative Care Australia.[12] This problem is particularly

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[7] Good P, Ravenscroft P, Cavenagh J. "Effects of opioids and sedatives on survival in an Australian inpatient palliative care population", *Internal Medicine Journal*, 2005; 35(9):512-7.

[8] Laviano A, Meguid MM, Inui A, Muscaritoli M, Rossi-Fanelli F. "Therapy insight: cancer anorexia–cachexia syndrome—when all you can eat is yourself", *Nature Clinical Practice Oncology*, 2005;2(3):158-65.

[9] Connolly A, Bird S, Allingham S et al. "Patient outcomes in palliative care in Australia. National Compendium Report January – June 2016." Palliative Care Outcomes Collaboration. Australian Health Services Research Unit, University of Wollongong, NSW Australia, website: www.pcoc.org.au; Clark K, Connolly A, Clapham S et al. "Physical symptoms at the time of dying was diagnosed: a consecutive cohort study to describe the prevalence and intensity of problems experienced by imminently dying palliative care patients by diagnosis and place of care", *Journal of Palliative Medicine*, 2016, 19(12): 1288–1295. doi:10.1089/jpm.2016.0219.

[10] Hudson PL, Kristjanson LJ, Ashby M, Kelly B, Schofield P, Hudson R, et al. "Desire for hastened death in patients with advanced disease and the evidence base of clinical guidelines: a systematic review", *Palliative Medicine*, 2006;20(7):693-701.

[11] Australian Institute of Health and Welfare 2021. "Palliative care services in Australia." 26 May 2021. Canberra: AIHW. https://www.aihw.gov.au/reports/palliative-care-services/palliative-care-services-in-australia

[12] Palliative Care Australia 2019, "Palliative Care 2030 – working towards the future of quality palliative care for all". PCA, Canberra, https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2019/02/Palliative-Care-2030-public.pdf, p.6.

acute in rural, regional and remote NSW. For example, the current inquiry into Health outcomes and access to health and hospital services in rural, regional and remote New South Wales received a submission from Manning Valley Push for Palliative, which has had to fundraise to "co-fund its own palliative care as it has not been able to get adequate government recognition, funding and support". This was not disputed by NSW Health, in response to questions on notice.[13]

21. We echo the concern expressed by Palliative Care Australia in a 2019 report: "With the introduction of Voluntary Assisted Dying (VAD) in Australian jurisdictions it is also important that an individual choice to request VAD is not a choice based on a lack of access to palliative care."[14]

22. It is essential that people approaching the end of life should be able to make an informed choice, and they can only do this if they are fully aware of palliative care options, have access to appropriate palliative care, and experience for themselves whether palliative care can alleviate their suffering before coming to the conclusion that their suffering cannot be relieved in a way they consider tolerable. For this reason, we recommended the following amendments to the Bill.

    a. Amend Section 4(1)(i)

    4(1)(i) a person who is a regional resident is entitled to the same level of access to **medical treatment, palliative care and** voluntary assisted dying as a person who lives in a metropolitan region,

    It is not appropriate for the Parliament to commit itself to the principle of equal access to voluntary assisted dying 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.

    b. Amend section 180(2)

    180(2) The access standard must specifically set out how the Ministry intends to facilitate access to **medical treatment, palliative care and** voluntary assisted dying for regional residents.

    c. Reinstate the requirement to offer a referral to a palliative care specialist

    Insert new section 28(4), with consequential renumbering
    28(4) In addition, the coordinating practitioner must offer to refer the patient to a palliative care specialist. The patient is not required to accept the offer of referral.

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[13] https://www.parliament.nsw.gov.au/lcdocs/other/15877/AQON%20-%20NSW%20Health%20-%20received%204%20August%202021.pdf

[14] https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2019/02/Palliative-Care-2030-public.pdf, p3

This echoes s.19(3) of the Voluntary Assisted Dying Bill 2017 (NSW), which required a medical practitioner to offer to refer the patient to a palliative care specialist.

d. Modify eligibility criteria in section 16(1)(d)(iii)

> (iii) is causing suffering to the person that, **having pursued reasonably available options to alleviate suffering**, cannot be relieved in a way the person considers tolerable.

The purpose of this amendment is to require the coordinating practitioner to ask whether the patient has investigated the effectiveness of palliative care or other treatment options to alleviate their suffering, before coming to the conclusion that the suffering is intolerable.

In jurisdictions where euthanasia and/or assisted suicide is legal, intolerable suffering does not rank as one of the top 5 reasons why people request euthanasia. Research suggests that psycho-social problems are more often a reason to request euthanasia.[15] One peer-reviewed study shows that in the US, "the dominant motives are loss of autonomy and dignity and being less able to enjoy life's activities".[16] In Oregon and Switzerland, studies have shown that people who request death are less motivated by physical pain than by the desire to remain autonomous.[17] According to Diane Meier, a leading palliative-care physician and professor of geriatrics in the US, "the movement to legalize assisted suicide is driven by the 'worried well', by people who are terrified of the unknown and want to take back control."[18]

The model of managed dying through palliative care is the basis of medical practice in Australia. It is the model attested to by both the Australian Medical Association and the World Medical Association. The goals of medicine involve the preservation of life where possible and comfort care when cure is not possible, while neither hastening nor deferring death. This legislation should do everything possible to encourage a patient to consider this alternative before considering VAD.

(ii) The Lack of Essential Safeguards

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[15] Breitbart W, Rosenfeld B, Gibson C, Pessin H, Poppito S, Nelson C, et al. "Meaning-centered group psychotherapy for patients with advanced cancer: A pilot randomized controlled trial", *Psycho-Oncology*, 2010; 19:21-28.

[16] Emanuel, op. cit.

[17] Aviv, op. cit.

[18] Aviv, op. cit.

23. The Voluntary Assisted Dying Bill 2021 omits essential safeguards, many of which were present in the 2017 Bill, notwithstanding the fact that the earlier Bill was rejected by the Parliament as insufficient. As an aside, these omissions demonstrate the trajectory of VAD legislation in Australia, in that what were considered essential safeguards four years ago are now considered unnecessary.

    a) Clause 17 of the Voluntary Assisted Dying Bill 2017 (NSW) required an examination by "a specialist in the medical profession that is relevant to the diagnosis or treatment of the terminal illness from which the patient is suffering". There is no equivalent provision in the current Bill. In this Bill, the coordinating practitioner—who makes the decision about a patient's eligibility for euthanasia and assisted suicide against the eligibility criteria (25(2)), and provides the patient with information about their diagnosis and prognosis, treatment options and the likely outcomes of that treatment, and palliative care treatment and the likely outcomes of that treatment (28(2))—need not be a specialist in the patient's disease, illness or medical condition, nor in palliative care. Patients making a decision about ending their lives should be examined by a specialist and receive specialist advice. The 2017 Bill also required that the patient's two medical practitioners had to be independent of each other. This should be reinstated.

        Insert new Clause 18A (based on clause 17 of the 2017 Bill)

        18A. Either the coordinating practitioner or consulting practitioner must be registered under the Health Practitioner Regulation National Law in a specialty in the medical profession that is relevant to the diagnosis or treatment of the terminal illness from which the patient is suffering, and the coordinating practitioner or consulting practitioner must be independent of each other.

    b) Clause 20 of the Voluntary Assisted Dying Bill 2017 (NSW) required a patient to be examined by a qualified psychiatrist or psychologist after they made a first request for euthanasia or assisted suicide. There is no equivalent mental health safeguard in this Bill. Clause 27(2) requires a referral to psychiatrist or psychologist only in the case where the coordinating practitioner is unable to decide whether a patient has decision-making capacity, or unable to decide if they are acting under duress. It is an essential safeguard that a qualified professional make the assessment that the patient has decision-making capacity, and has made the request to end their life freely, voluntarily and after due consideration.

        New Division 4A, containing clause 42A (based on clause 20 of the 2017 Bill)
        42A **Examination by qualified psychiatrist or psychologist**
        (1) After the patient has been examined by the coordinating practitioner and the consulting practitioner, the patient must be examined and assessed by a qualified psychiatrist or a qualified psychologist.

(2) The qualified psychiatrist or qualified psychologist must not be closely associated with the patient, the coordinating practitioner or the consulting practitioner.

(3) The qualified psychiatrist or qualified psychologist must provide to the coordinating practitioner and the consulting practitioner a written report of the assessment of the patient under this section.

(4) The coordinating practitioner must not provide assistance to the patient under this Act unless the qualified psychiatrist or qualified psychologist, after examining the patient, makes an assessment that, in the opinion of the qualified psychiatrist or qualified psychologist:

(a) the patient has decision-making capacity in relation to the request for assistance, and

(b) the patient's decision to request the assistance has been made freely, voluntarily and after due consideration.

(5) In this section:

qualified psychiatrist means a person who is registered under the Health Practitioner Regulation National Law in the specialty of psychiatry in the medical profession.

qualified psychologist means a registered psychologist whose registration under the Health Practitioner Regulation National Law in the health profession of psychology is endorsed under that Law as being qualified to practise in the area of clinical psychology.

c) Mental capacity should be assessed, not presumed.

Clause 6(2) seeks to create a statutory presumption of decision-making capacity "unless the patient is shown not to have the capacity". This is inappropriate, because there is no requirement for the coordinating practitioner or consulting practitioner to make enquiries into the mental capacity of a patient (such as consulting with other medical professionals who have provided long term care to the patient about the patient's prior medical history). This presumption should be reversed such that capacity must be demonstrated, rather than assumed.

6(2) For the purposes of this Act, coordinating practitioner or consulting practitioner must assure themselves, on reasonable grounds, that a patient has the mental capacity to understand information or advice about voluntary assisted dying, and the implications of that information and advice.

d) Prior medical history should be considered.

Section 25(3) allows, but does not require, the coordinating practitioner to consult with another health practitioner about the medical history of the patient. This clause should be modified to require this consultation where the coordinating practitioner is not familiar with the medical history of the patient.

> 25(3) **If the coordinating practitioner is not familiar with the medical history of the patient, they must make reasonable efforts to familiarise themselves with the patient's medical history.** Nothing in this section prevents the coordinating practitioner from having regard to relevant information about the patient that has been prepared by, or at the instigation of, another registered health practitioner.

e) The definition of 'pressure or duress' is inadequate.

One of the expressed principles of the Bill is "there is a need to protect persons who may be subject to pressure or duress" (see 4(1)(j)).

'Pressure or duress' is defined in the dictionary in Schedule 1 as including "abuse, coercion, intimidation, threats and undue influence". This definition is too narrow because it does not explicitly cover subtle forms of influence and control.

Elder abuse and the risk of elder abuse are increasing threats in Australia. A 2015 NSW Parliamentary inquiry revealed shocking accounts of elder abuse. It is naïve to think that the limited safeguards in the Bill will prevent manipulation of the vulnerable and frail aged. The NSW Parliament Legislative Council General Purpose Standing Committee No. 2 report on elder abuse reported that:

> "a common factor seen across all types of abuse is a relationship where the older person is in some way dependent on another person for their day to day needs. Research suggests this pattern is often seen in cases of financial abuse and neglect, as well as for many cases of psychological, physical and sexual abuse. Personal relationships with family members or friends that come to include a caring role can also give rise to abuse".[19]

Those with a terminal illness are often "dependent on another person for their day to day needs", which makes them vulnerable to abuse from those with carer responsibilities. The report devotes a chapter to financial elder abuse, citing multiple case studies of breach of trust, coercion, misuse of enduring powers and "inheritance impatience". Only some of these actions would be caught by the current, limited definition of pressure or duress.

People must have the right to live to the extent of their natural life without an induced guilt associated with 'hanging on'. Abuse is likely to remain hidden because of the difficulties inherent in assessing and reporting abuse. According to American ethicist Scott Rae, "most of the conversations where people are

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[19] Paragraph 2.10, Legislative Council General Purpose Standing Committee No. 2. "Elder Abuse in New South Wales." 24 June 2016. https://www.parliament.nsw.gov.au/lcdocs/inquiries/2387/Report%2044%20-%20Elder%20abuse%20in%20New%20South%20Wales.pdf.

persuaded to sign a declaration for assisted suicide or euthanasia occur out of public view."[20] It is difficult to prove that a patient has requested assisted death, without any pressure from society, family or medical practitioners. Moreover, it is almost impossible to prevent.

Elderly Australians suffering from dementia are particularly susceptible to elder abuse. There are insufficient safeguards contained in the Bill to protect vulnerable older Australians suffering from dementia or other forms of cognitive impairment.

In the Common Law, there is a growing recognition of 'lawful act duress' that does not require the presence or threat of unlawful action in order for duress to be established. The Bill should also recognise the existence of 'lawful act duress' and expand this definition accordingly.

Modify the following definition in Schedule 1

pressure or duress includes abuse, coercion, intimidation, threats and undue influence. **It also includes emotional manipulation, economic pressure and lawful act duress.**

f) Recording of the cause of death should be accurate.

We do not support the proposed new section 43(3)(a) of the *Births, Deaths and Marriages Registration Act 1995 No 62* (NSW). This requires that a person's underlying illness that made the person eligible for euthanasia or assisted suicide be listed as the cause of death, rather than the administration of a lethal substance. The purpose of a death certificate is to accurately record, among other things, the cause of a person's death and so should reflect that the cause of death was a lethal drug, either self-administered or practitioner-administered.

g) Reporting to and by the Coroner

Clause 32 of the Voluntary Assisted Dying Bill 2017 required that all euthanasia and assisted suicide deaths be reported to the NSW Coroner. Schedule 3 of that Bill also modified the Coroners Act 2009 to require the Coroner to provide reports to the Attorney General on assisted deaths. This safeguard has been omitted from the Bill currently before Parliament, but should be reinstated.

iii) Residential aged care facilities should not be forced to participate in VAD

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[20] Rae S., in Hastie P. "Opening Pandora's Box", *Australian Presbyterian*, Winter 2017, p.6.

24. Residential aged care facilities which are run by religious bodies should not be forced to allow any aspect of euthanasia or assisted suicide on their premises. This is an infringement on the freedoms of belief, conscience and association. Section 98 already requires residential aged care facilities that do not provide relevant services (as defined) to publish that information, meaning current and incoming residents will be aware that euthanasia and assisted suicide are not available.

25. However, provisions in clauses 92-97 require aged care facilities to provide access to medical practitioners and others who otherwise do not treat the residents or have any association with the facility. Facilities are required to allow such practitioners to consult with patients, prescribe and even administer lethal drugs on facility premises.

26. Our preferred recommendation is that these provisions should be deleted, so that a residential aged care facility is not forced to participate in any aspect of the VAD process. However, at an absolute minimum, the following amendments should be made to the Bill:

    a. an amendment to section 89(3), so that the right to decide not to provide physician-assisted suicide is not subject to Part 5, Division 2, subdivision 3, which outlines the process for the administration of a ‘voluntary assisted dying substance’;

    b. an amendment to Part 5, Division 2, Subdivision 3 to make it clear that there is no obligation on approved providers of residential aged care to allow physician-assisted suicide (i.e., the administration of a ‘voluntary assisted dying substance’) to be administered at their facility; and

    c. amendments to section 97 to expressly provide that, in the event that a permanent or non-permanent resident of a residential facility is preparing for the administration of a ‘voluntary assisted dying substance’ and they reside at a facility which does not provide physician-assisted suicide, the facility will engage with the resident to transfer them to an alternative location where the resident can receive the ‘voluntary assisted dying substance’.

27. These amendments would assure Christian residential aged care providers of legislative protection for refusing to engage in physician-assisted suicide. These amendments would enable residents in these facilities to engage in the administrative process that underpins physician-assisted suicide while at that facility, but would permit the operator of the facility to require the resident to be transferred to another facility (or a private residence) in order to access the ‘voluntary assisted dying substance’. This ensures that the act of physician-assisted suicide does not take place at a facility which is fundamentally opposed to it. It also allows for members of our congregations who want to reside in an environment

where physician-assisted suicide and euthanasia are not allowed in order to feel safe and protected by the institution.

28. These limited amendments proposed in relation to residential aged care facilities provide a mechanism for those who wish to make use of the provisions of Bill, while at the same time respecting the choice of the vast majority of the residents for whom the residential aged care facility is both their home and a community of life-giving care, who do not want physician-assisted suicide and euthanasia practiced in their community.

Conclusion

As a community, we are rightly concerned about the suffering those with terminal illness may face. However, assisted dying legislation opens the way for state-sanctioned killing which may lead to abuse and expansion beyond its original intent. This is an intolerable way to run healthcare. Palliative care provides a legal, effective, holistic and ethical option for helping people with terminal illness. The Bill before the parliament should be rejected, because it prioritises Voluntary Assisting Dying over palliative care.

Advocates of the right to die argue that this draft Bill contains sufficient protections for the vulnerable. We reject that any eligibility criteria can be adequately implemented and enforced in a way which protects the vulnerable from abuse. It is because of this documented abuse in other jurisdictions that we do not accept that any safeguards will be sufficient to protect the vulnerable. The Bill before the parliament is manifestly inadequate in this regard. We have identified 8 essential safeguards which are absent, many of which were present in the 2017 Bill (which was itself rejected as inadequate).

Euthanasia and physician-assisted suicide are contrary to the fundamental religious beliefs of many in our society. Although the Bill does provide some conscience protections for health practitioners, the protections for religious freedom are insufficient. The Bill requires a residential aged care facility to allow and facilitate voluntary assisted dying, notwithstanding the fact that the institution has a publicly available policy to inform current and incoming residents about its opposition to euthanasia and assisted suicide. This fails to respect the rights of elderly Australians to choose residential aged care where they will not be offered Voluntary Assisted Dying, and fails to respect the right of religious bodies to operate in conformity to their doctrines, tenets and beliefs.

In light of these substantive deficits, we submit that the Voluntary Assisted Dying Bill 2021 should be rejected by the Committee and the Parliament.

Bishop Michael Stead

22 November 2021