Submission No 45

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Organisation: Cherish Life

Date Received: 22 November 2021

Cherish Life's submission to the New South Wales Parliament regarding the *Voluntary Assisted Dying Bill 2021*.

Cherish Life is grateful to New South Wales Parliament for the opportunity to make a submission against the "Voluntary Assisted Dying" Bill 2021 (the Bill hereafter).

Cherish Life is opposed to all form's euthanasia and assisted suicide, and therefore are entirely opposed to the Bill – we recommend an outright rejection of the legislation by the NSW Parliament.

Euthanasia and assisted suicide is a dangerous social demand, and not healthcare. While this submission will specifically address a few aspects of the Bill, we take a moment to highlight a few reasons why euthanasia and assisted suicide is wrong and legalising end of life killing would be a dangerous path for NSW to go down:

- The Australian Medical Association is against euthanasia of any kind.
- All the peak medical advisory or representative bodies in Australia are opposed to euthanasia, and as are many around the world including the World Medical Association.
- Euthanasia legalisation is rejected by the vast majority of those on the front line of caring for the sick, elderly and disabled.
    - 101 Victorian oncologists wrote against euthanasia: "Assisted suicide is in conflict with the basic ethical principles and integrity of medical practice."
    - The majority of pallaitive care specialists are opposed to euthanasia (see appendices for the full letter)
- It is a slippery slope and tragically Belgium is now euthanising children.
- It is utterly counter-productive to combating Australia's suicide problem.
- Suicide concerns: a number of jurisdictions where assisted suicide has been legalised have recorded a marked overall increase in suicides, including non-assisted suicides, afterwards. This is because the legalisation of assisted suicide normalises all suicide, tragically (section ii of this submission touches on this).
- Euthanasia is not healthcare, it is a social demand based on fear and principals of extreme autonomy. Doctors should kill the pain, not the patient.
- Euthanasia would be open to terrible manipulation and abuse. Cases of people being "euthanised" against their will have occurred.
- Euthanasia inherently devalues human life, particularly those who are elderly, sick or disabled.

- Victoria, Australia's euthanasia rates have been very concerning since legalisation in 2017. The Victorian Premier thought there would be 1 per month, there are on average two a week.
- Despite Victoria and other places boasting of "safeguards" the truth is euthanasia of any kind is never safe.
- No jurisdiction where euthanasia has been legalised has been able to safeguard against wrongful deaths, which include deaths caused by wrong diagnosis, wrong prognosis, patients being unaware of available treatment or having no access to palliative care, or coercion and elder abuse.
- Palliative care and euthanasia are not complementary, as euthanasia typically cannibalises palliative care funding and resources.
- When euthanasia was legalised in Western Australia last year, an amendment to give people in the regions the same access to palliative care as those in metropolitan areas was defeated. This tragic outcome shows it's not about freedom of choice by about legalising assisted suicide and euthanasia.
- If euthanasia was legalised, any terminally ill patients, who need love and care, would feel pressure - whether real or imagined - to do "the right thing" and request euthanasia so they are not "a burden on their family". We must protect the most vulnerable amongst us, which includes the elderly, disabled and / or terminally ill.
- Euthanasia can be the end result of economic rationalism at its worst, as it's far cheaper to prescribe poison for people than to set up a world-class palliative care system for the ill. We can't let government's get away with killing people to save money.

We are deeply concerned that if enacted the legislation would lead to many extra deaths in NSW every year. Including wrongful deaths due to suicide contagion as well as from people accessing euthanasia or assisted suicide due to error, coercion, or because of insufficient palliative care services to their area meant felt they had no other "choice", ironically.

Our submission against the Bill seeks to:

I. suggest amendments which would make what we deem a very dangerous Bill, less dangerous, and
II. warn the Parliament that it's likely that there would be many extra deaths in Queensland every year if this Bill were to pass, and
III. present a case for enshrining in law equitable access to palliative care services, as this Bill exacerbates the current barriers and inequalities many NSW residents face in accessing to specialist palliative care services.

The Bill is intrinsically flawed as it hinges on a false pessimistic dichotomy which holds the basic view "That unless the government facilitates people being able to kill themself or be killed at the end of life, they will die in terrible pain." This grim and frightening picture is simply not true. World-class palliative care available across NSW is what is needed and is the real "dying with dignity", and indeed palliative care specialists can

mitigate physical suffering. Hundreds of Australian Palliative Care specialists were signatory to an open letter in 2017 which addressed fallacy that palliative care was ineffective against some pain, stating "*Current Australian data indicates that no more than 2 in every 100 Palliative Care patients would be in moderate or severe pain at the end of life. In these unusual cases where when all other methods of palliation for pain and other symptoms is inadequate, and if the patient agrees, palliative sedation therapy is available to provide adequate relief of suffering."*[1]

Another consideration is extensive polling of Queensland voters regarding euthanasia and palliative care in September 2021 revealed that 99% of Queenslanders thought that everyone in the state should have access to adequate palliative care and 90% of Queenslanders wanted to see the states palliative care funding increased to be in line with Palliative Care Queensland recommendations. There would be very similar results in NSW as it is a similar demographic and other polls run in both states show very similar results (a copy of the polling is at the end of this submission) .

**Cherish Life Queensland (formerly known as Queensland Right to Life) was established in 1970 and advocates for the right to life from conception until natural death. The "right to life' essentially means the right not to be killed. We are a passionate community comprising tens of thousands of mostly Queenslanders from a diversity of backgrounds. We also have a national entity Cherish Life Australia which reaches across the nation.*

[1] An open letter to Australian politicians signs by hundreds of Palliative Care Specialists in 2017, a copy is in the appendices.

PART I: SUGGESTED AMENDMENTS

AMENDMENT 1

INDIVIDUAL MEDICAL PRACTITIONERS' SHOULD BE GRANTED THE RIGHT TO A FULL CONSCIOUS OBJECTION TO EUTHANASIA AND ASSISTED SUICIDE.

A health practitioner who has a conscientious objection to voluntary assisted dying is still mandated to perform acts that help a patient obtain access to assisted dying. This means that the doctor with a conscientious objection to euthanasia or assisted suicide is still complicit with the outcome of a patient killed, either by assisted suicide or euthanasia. This is completely unacceptable. The right to a conscientious objection is Australian and international laws. Should these objections be based on religious beliefs, the right to practice these beliefs and not to be forced to participate in an action against one's faiths are also firmly in place in law.

A full conscientious is required, a full conscientious objection meaning the right to not provide information on it, the right not to have to perform euthanasia or prescribe poison and the right not to refer patients to doctor who performs euthanasia or facilitates assisted suicide.
It's clear the Bill holds someone's "right" to access euthanasia or assisted suicide as the highest "right" which is unfair and unbalanced.

If the purpose of this overreaching provision is to ensure that everyone who seeks access to assisted dying will receive it, the provision goes beyond what is necessary to achieve that purpose. For instance, information about official voluntary assisted dying care navigator services can be made readily available on the NSW Health Department's website.

Professor David Albert Jones of the Anscombe Bioethics Centre at Oxford comments on the issue:

'In the first place it utterly fails to establish the duty of doctors to object to practices and procedures that are unconscionable because harmful, discriminatory, unjust or unethical. The right to conscientious objection is based on the duty to be conscientious which is fundamental to medical ethics. In the second place, "conscientious objection" is presented as conflicting with "patient care". This overlooks the fact that there can be no adequate patient care without conscientious healthcare professionals.… if a doctor objects in conscience to participation in torture or capital punishment or to force feeding of a prisoner who is on hunger strike, it would be unprincipled for them to find someone with fewer scruples to do the deed for them. To require a conscientious objector to facilitate delivery of the procedure to which they object is a direct attack on person's conscience and moral integrity, and thus a serious harm to them. It would be much better to say nothing about conscientious objection than to undermine it by imposing a requirement for "effective and timely referral".'[2]

[2] Michael Cook, "World Medical Association moots mandatory referral for abortion and euthanasia", *BioEdge*, 30 May 2021 <https://www.bioedge.org/bioethics/world-medical-association-moots-mandatory-referral-for-abortion-and-euthanasia/13817>.

Dr Bernadette Flood explains:

“Conscientious objection is a right derived from the right to freedom of thought, conscience and religion, as set out in the Universal Declaration of Human Rights. The right to conscientious objection is not a right per se since international instruments of the United Nations do not make direct reference to such a right, but rather is normally characterised as a derivative right; a right that is derived from an interpretation of the right to freedom of thought, conscience and religion.”[3]

The European Centre for Law and Justice states:

'Conscience is proper to human beings and the source of justice. Article 1 of the Universal Declaration of Human Rights defines human beings as “endowed with reason and conscience“. The universality of conscience is the source of universality of justice and human rights.'[4]

Dr Clair de La Hougue, fellow of the European Centre for Law and Justice, elucidates:

“As human beings are endowed with conscience and able to make a moral judgement, conscientious objection is both a duty, enshrined in Principle IV of the Nuremberg Principles, and a right. This is why it was already mentioned in the Convention and the Covenant. The development of international human rights law has led to recognise objection as an integral part of freedom of conscience.”[5]

In General Comment 22 (1993) on Article 18, the Human Rights Committee (HRC) stated that “The Covenant does not explicitly refer to a right to conscientious objection, but the Committee believes that such a right can be derived from article 18, inasmuch as the obligation to use lethal force may seriously conflict with the freedom of conscience and the right to manifest one's religion or belief.”[6]

A law which disallows a doctor’s conscientious objection is likely to deter the most conscientious young people from becoming doctors. Would this be in the public interest? The Hippocratic Oath states: “I will give no deadly medicine to anyone if asked, nor suggest any such counsel...” Forcing a medical practitioner to advise a patient on how to access voluntary assisted dying flies in the face of basic medical ethics.

Frank Brennan observes:

“Australia is a signatory to the International Covenant on Civil and Political Rights. The

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[3] Bernadette Flood PhD M.P.S.I., “Assisted Suicide and Euthanasia: pharmacists must also have the right to conscientious objection”, *Life Institute* <https://thelifeinstitute.net/blog/2021/assisted-suicide-and-euthanasia-pharmacists-must-also-have-the-right-to-conscientious-objection>.

[4] “The right to conscientious objection of medical practitioners”, *United Nations Human Rights Council*, Session 31, Geneva, 8 March 2016 <https://www.fiamc.org/bioethics/conscientious-objection/the-right-to-conscientious-objection-of-medical-practitioners/>.

[5] Dr Clair de La Hougue, “The right to conscientious objection of medical practitioners”, *United Nations Human Rights Council*, Session 31, Geneva, 8 March 2016 <http://9afb0ee4c2ca3737b892-e804076442d956681ee1e5a58d07b27b.r59.cf2.rackcdn.com/ECLJ%20Docs/The%20right%20to%20conscientious%20objection%20of%20medical%20practitioners%2C%20Dr%20Claire%20de%20La%20Hougue.pdf>.

[6] *Ibid.*

terms of that Covenant provide a convenient benchmark for most individuals and groups who espouse human rights. The freedom of conscience and religion is one of the few non-derogable rights in the Covenant. This means that a signatory may not interfere with the exercise of the right even during a national emergency — whereas other rights in the Covenant can be cut back during times of public emergency which threatens the life of the nation — but only to the extent strictly required by the exigencies of the situation and provided that that cut back applies in a non-discriminatory way to all persons."[7]

The weak and contradictory provisions for conscientious objection in the *Voluntary Assisted Dying Bill 2021 (Qld)* do not uphold Australia's international obligations.

In addition, under the *Fair Work Act 2009 (Cth)*, employees are to be protected from coercion (s343) and undue influence or pressure (s344). When the legislature forces medical practitioners to participate materially in acts against their conscience, that nullifies laws designed to protect them at work.

Other Australian jurisdictions have better protections for individual doctors that this Bill proposes.

VIC: "Written into the law is a strong protection for health professionals who have a conscientious objection to euthanasia.[8]They can refuse to be involved in any aspect of the process — including prescribing the medication, providing information or being present when the drug is taken.

Health professionals are also under no obligation to refer a patient to a doctor who is willing to participate."

WA: "Health practitioners are also able to refuse to participate in voluntary assisted dying for any reason (including conscientious objection)[9]. Health care workers must not initiate discussion about, or suggest, voluntary assisted dying to a person to whom they are providing health or professional care services. The exception to this is for medical practitioners or nurse practitioners if, at the same time, they also inform the person about treatment and palliative care options available to them and the likely outcomes of that care and treatment."

Likely affects if enacted

The NSW government needs to look at the likely effects of such legislation if enacted:

- It's likely it would lead to employment and workplace discrimination against those with objections to euthanasia and assisted suicide, whether they be founded on religious beliefs or otherwise.
- This could also pass onto discrimination in university placements for hopeful medical students.

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[7] Frank Brennan, "Euthanasia: doctors' conscience vs patient rights", *Eureka Street*, 2 March 2009 <https://www.eurekastreet.com.au/article/euthanasia—doctors--conscience-vs-patient-rights>.

[8] https://www.abc.net.au/news/2018-11-09/euthanasia-assisted-dying-in-victoria-enabling-choice-for-dying/10478420

[9] https://ww2.health.wa.gov.au/voluntaryassisteddying

- Regional and rural areas may witness even less doctors putting up their hand to service those areas, for fear they will be called upon to be party to euthanasia and assisted suicide.
- Some doctors may also prefer to leave the profession rather than be complicit in killing a patient, as some have already indicated. This would lead to further under resourcing of the NSW Health System, the pinch of which would probably be felt in already suffering regional areas.
- Some doctors many choose not to treat geriatric or terminally ill patients for fear they may be asked about assisted suicide or euthanasia.

The question also must be asked: given the fact that the Australian Medical Association* and the vast majority of oncologists and palliative care specialists (who do the lion's share of end of life care) are opposed to euthanasia and assisted suicide – what right does NSW politicians to force doctors to be complicit in it? Why aren't the parliamentarians listening to the doctors and medical fraternity? It's not the politicians sitting in parliament who will have to do the killing, it is the doctors who have trained for decades to save life.

The lack of a full conscientious objection in the Bill in its current states is both brutal and unfair, it needs to be amended to grant doctors a full conscientious right.

*****The Australian Medical Associations position statement on euthanasia and assisted suicide states " The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life."[10]

Similarly 107 out of 109 of the world's national medical bodies are opposed to euthanasia and assisted suicide.

AMENDMENT 2

INSTITUTIONS BE GIVEN THE RIGHT OF A FULL INSTITUTIONAL CONSCIENTIOUS OBJECTION.

It is somewhat ambiguous whether faith-affiliated providers i.e. Catholic Health Australia, UnitingCare, BaptistCare, Anglicare as well as many others would be forced to supply them residents or patients with information on euthanasia or assisted suicide, and allow euthanasia and assisted suicide doctors onto the premise.

In the case where the patient is a permanent resident of a facility, like an aged care home for example, it seems the institution could be forced to let the assisted suicide or euthanasia take place on the premises by an outside doctor coming in to kill the patient or the poison being delivered to the facility. This is outrageous to say the least.

Once again, the "balance of rights" is wildly out of kilter, strongly favouring the "right "of individuals seeking euthanasia and assisted suicide over the right of these institutions to

[10] AMA's position statement on Euthanasia, 2016, https://www.ama.com.au/position-statement/euthanasia-and-physician-assisted-suicide-2016

abide by their charter, as well as the rights thousands of individuals who work in these faith-affiliated established places of healing and care.

The Bill's lack of a full conscientious objection for institutions is extreme, discriminatory and out of step with other Australian jurisdictions (except Queensland which compels faith-affiliated institutions to be complicit with euthanasia and assisted even on their premises).

The SA law explicitly allows hospitals the right to refuse to authorise or permit "any part" of the VAD process. The identical provisions should be enshrined in this NSW Bill.

It could be argued that this extreme legislation is in breach of right to freedom of thought, conscience and religious obligations. Australia is a party to seven key human rights treaties. The most relevant obligations when discussing voluntary euthanasia are contained in the *International Covenant on Civil and Political Rights* (ICCPR).[204] The following rights in the ICCPR may be engaged by the practice of voluntary euthanasia[11]:

- right to life (article 6)
- freedom from cruel, inhumane or degrading treatment (article 7)
- right to respect for private life (article 17)
- freedom of thought, conscience, and religion (article 18).

It could also be argued that the "right" of residents of a Catholic or other Christian nursing home to choose a place of residence in accordance with their faith, is being flouted or even trampled on. For example, a Catholic resident wouldn't want the resident (and presumably friend) in the next room being killed one day by a 'VAD' doctor coming on premise with a lethal needle. It would be deeply distressing for all the other residents and staff to say the least. Where are the other residents' rights in this scenario? A right to peacefully live in a place that advertises it shares that faith? Once again a strong, unfair and arguably unlawful bias towards the "right" of the euthanasia seeker.

Likely affects if enacted

If institutions aren't allowed to operate within their theological or ethical charter by having a complete institutional conscientious objection to euthanasia or assisted suicide, this would undoubtedly be viewed be an impediment to their continuing care of the dying. All of these health care providers are not-for-profits and some run at a loss in a humane bid to make sure no one is without care. These institutions are life-centric - having to be complicit with a patient killed may be the last straw for some of them. Such an iron-fisted lack of respect for their values may lead to a number of them closing hospitals, hospices and aged care facilities. This very real possibly was raised at Queensland Health Committee End of Life Enquiry on 4 July 2019 the head of Southern Cross Care stating

[11] ICCPR number 204, which Australia is party to, can be found here: https://humanrights.gov.au/our-work/age-discrimination/publications/euthanasia-human-rights-and-law

"If PAS [physician assisted dying] legislation becomes mandatory or there are inadequate provision for conscientious objection then, rather than compromise their ethical standards, many aged care providers, particularly those from a Judeo Christian religious tradition, may exit the industry."[12]

Will we eventually see such entities lose not-for-profit status in an attempt to punish them for abiding by their ethical standards? This was the fate faced by a small hospice in British Columbia, the Irene Thomas Hospice.[13]

Will there be intentional set-ups and lawsuits against faith-based health care institutions and individuals who refuse to be complicit with euthanasia and assisted suicide?

A number in our community are in retirement villages or nursing homes run by faith-based groups. One of the reasons they chose those facilities was because they were aligned with their Christian values, the thought that an outsider is able to come in, onto the premise and help kill a fellow resident, is both distressing and frightening.
Questions:
Why does the right of a relative few right trump the collective right of many to exercise their conscience as a group?

Why isn't the state government pursuing a better deal for faith-based health care providers should this Bill pass?

The Bill must be amended, or made crystal clear, so health institutions of faith have the right to a full institutional conscientious objection to euthanasia and assisted suicide.

AMENDMENT 3

THE PATIENT TO BE SEEN BY A SPECIALIST, AT LEAST ONCE, FOR FREE IN THE AREA OF THE PATIENTS' ASSUMED ILLNESS (EG AN ONCOLOGIST FOR A SUSPECTED CANCER PATIENT)

The Bill has no requirement to see by a specialist. This is particularly remiss; there's no doubt it would cause wrongful deaths, particularly those from disadvantaged backgrounds, and here's why.

This presents a problem from many angles:

[12] Queensland Parliament Health Committee, End of Life Enquiry interview of witnesses, 9 July 2019

[13] Xavier Symons, "Canadian hospice could be defunded because it opposes euthanasia", *BioEdge*, 18 January 2020 <https://www.bioedge.org/bioethics/b.c.-hospice-could-lose-funding-over-maid-stance/13290>.

1. In practice this could mean the doctor giving the 6 month prognosis to a newly graduated general practitioner (GP) with little or no specialised training in the person's area of suffering. This is a major red light. Incorrect diagnoses happen at a rate of 10 to 15 per cent[14]. Wrong prognosis are also not uncommon, "predicting prognosis and the timing of dying can be difficult"[15] a study on the accuracy of prognosis revealing "Of the 2700 predictions, 1226 (45%) were off by more than 6 months and 488 (18%) were off by more than 12 months."[16] While a 2000 study in the British Medical journal found that 80 per cent of prognoses for terminally ill patients were incorrect[17]. Coupled together with the additional errors that can arise because of the relative inexperience of a newly graduated GP, opposed to a specialist of 30 years, the total error rate by receiving a diagnosis and prognosis from an inexperienced GP, for example, could be as high as 50 per cent This huge chance for a deadly error is enough to warrant the government funding what is deemed a terminally ill patient for a specialist assessment.

2. Without seeing a specialist in the area of a patients suffering they may miss out on the latest and best treatment for that particular condition, which in some instances may actually save their life.

3. Economic barriers to seeing a specialist. Specialists don't bulk bill, unless a patient is seeing one at a public hospital in a critical care type scenario. The Bill as it stands favours those with medium to high-cash flows who can afford to see a specialist. Put another way, the poor and unemployed would in many cases receive a substandard level of medical care under this Bill. They would also be more likely to suffer a wrongful death, because they haven't seen a specialist in the area of their suffering, for reasons explained in point 1.

4. Geographic barriers to seeing a specialist. People in regional NSW have less access to palliative care specialists and their services than those in metropolitan NSW, especially Sydney. Once again this is discrimination of sorts and a strong bias towards elevating euthanasia and assisted suicide above real healthcare which actually saves lives. Such a strong bias could also mean more people in regional NSW are casualties of wrongful deaths if this Bill were to pass.

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[14] According to Dr Stephen Best, NZ Medical Association President, recorded on 14 September, 2015 at https://www.stuff.co.nz/national/politics/84252580/euthanasia-too-final-when-the-risk-of-error-is-to-great--doctors

[15] Excerpt from Australian Government "Consensus Statement: essential elements for safe and high-quality end-of-life care, 2015", https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Consensus-Statement-Essential-Elements-forsafe-high-quality-end-of-life-care.pdf

[16] A UK study on the prognostic accuracy for brain cancer, recorded in https://pubmed.ncbi.nlm.nih.gov/24160479/

[17] Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study, British Medical Journal, https://www.bmj.com/content/bmj/320/7233/469.full.pdf

Amendments considered should be that a patient must be seen in person in the area of a persons assumed illness, eg an oncologist for suspected cancer.

AMENDMENT 4

PATIENT TO BE ASSESSED BY A PALLIATIVE CARE SPECIALIST (FOR FREE).

The right for anyone who is suspected of having a terminal illness to be seen and treated by a palliative care specialist, for free, from the point of terminal diagnosis should be written into this Bill.

Please see Section III for more details on this and the dire need for greater investment in palliative care in NSW.

AMENDMENT 5

A REQUIREMENT TO BE ACCESSED BY A PSYCHIATRIST PRIOR TO ACCESSING EUTHANASIA AND ASSISTED SUICIDE.

Depression due to their illness and feelings of hopefulness are often key drivers of requests for euthanasia and assisted suicide data from overseas shows.

A psychiatric assessment would be able to screen for people who are depressed or acting out of character, and then help them with their mental health. Such a provision would also help reduce the number of wrongful deaths due to underlying mental health illness or mental health disruptions, as well as suicide contagion that often accompanies legalising of euthanasia of any kind.

AMENDMENT 6

CAPPING THE NUMBER OF PATIENTS, THE DOCTOR CAN APPROVE OR SECOND FOR ‘VAD’.

That no one medical doctor can be the coordinating doctor or the second approving doctor for more than five (5) patients accessing euthanasia or assisted suicide in any 12 month period. This will mean no one doctor can make their primary occupation managing or seconding assisted suicide or euthanasia cases, as it should never be the primary intention of a doctor to take the life of their patient.

There is also the added risk that if a doctor routinely manages and / or approves euthanasia and assisted suicides there is a loss of sensitivity to the fact they are helping kill someone.

SECTION II: ANALYSIS: WHY LEGALISING ASSISTED SUICIDE & EUTHANASIA IS LIKELY TO LEAD WILL LEAD TO MORE DEATHS EACH YEAR IN NSW EACH YEAR

Summary – ***Empirical evidence from jurisdictions that have legalised euthanasia and/or assisted-suicide such as Victoria, the Netherlands, Belgium, Switzerland, Canada, Oregon and Washington State shows that the overall number and relative frequency (as a % of annual deaths/per 100,000 people) of both medically-assisted suicides and total suicides has increased dramatically. Overall, these regions have recorded an average increase of 55.8% in the number of total suicides committed each year. Additionally, since legalising assisted-suicide/ euthanasia the number and rate of non-assisted suicides in regions such as Victoria, the Netherlands and Oregon has increased.***

GLOBAL EVIDENCE OF EXTRA DEATHS EACH YEAR

A. European & North American Case Studies

Table 1 (below) provides a summary of the salient data from four jurisdictions—the Netherlands, Belgium, Switzerland and Canada—with some form of legalised euthanasia and assisted-suicide services. 'E & AS' figures represent the number of euthanasia (E) and assisted-suicide (AS) cases reported to the relevant reporting body for each respective country, while 'NAS' figures represent instances of non-assisted suicide. Total suicide figures represent this number + the number of non-assisted suicide cases from the corresponding year, with the aim of capturing the *overall level of suicidality* in each country.

In addition to absolute figures, statistics related to the relative frequency of E & AS cases and total suicides have been included, in order that the relative effect of each statistic can be gauged. All statistics also include a measure of growth (as a %) from the start of the period to the latest available data.

Overall, these figures illustrate a dramatic increase in almost every country for each category. For example, in the brief period since 2016 in which euthanasia and assisted-suicide have been legal in Canada, authorities have recorded a *454.8% increase* in the number of medically-assisted suicides and a *421.1% increase* in the percentage of annual deaths for which these suicides account. Moreover, from 2002 to 2018, the Netherlands has experienced a *116.3% increase* in the total suicide rate, with a peak of *49.8* suicides per 100,000 people in 2017, and a last recorded value of *46.3*.

The highest recorded growth is in the overall number of euthanasia and assisted-suicide cases in Belgium, which has grown an astonishing *1029.8%*. This is followed by Switzerland, which has recorded a *528.9% increase* in the number of cases of euthanasia and assisted suicide and a *503.4% increase* in the percentage of yearly deaths by these means. *(Please note that the full references for this section is at the back of this section.)*

	The Netherlands	**Belgium**	**Switzerland**	**Canada**
Legal Status	Legal since 2002	Legal since 2002*	Assisted suicide de facto legal since 1937*	Legal since 2016
# of Reported E & AS Cases				
Year of legalisation	1,882	235	187	1,015
1 year post-	1,815	349	203	2,833
5 years post-	2,120	704	253	
10 years post-	4,180	1807**	587	
Last recorded	6,126	2,655	1,176	5,631
Growth as %	***225.5%***	***1029.8%***	***528.9%***	***454.8%***
	(2002 - 2018)	*(2003 - 2019)*	*(2003 - 2018)*	*(2016 - 2019)*
% of Annual Deaths from E & AS				
Year of legalisation	1.3%		0.3%	0.4%
1 year post-	1.3%		0.3%	1.0%
5 years post-	1.6%	0.7%	0.4%	
10 years post-	3.0%	1.65%**	0.9%	
Last recorded	4.0%	2.4%	1.8%	2.0%
Growth as %	***207.7%***	***264.2%***	***503.4%***	***421.1%***
	(2002 - 2018)	*(2008- 2019)*	*(2003 - 2018)*	*(2016 - 2019)*
# of Total Suicides (E + AS + NAS)				
Year of legalisation	3,449		1,456	4,992
1 year post-	3,315		1,487	6,991
5 years post-	3,473	2,704	1,566	
10 years post-	5,933	3700**	1,657	
Last recorded	7,955	3,931	2,178	9,642
Growth as %	***130.6%***	***45.4%***	***49.6%***	***93.1%***
	(2002 - 2018)	*(2008- 2016)*	*(2003 - 2018)*	*(2016 - 2019)*
Total Suicide Rate per 100,000 (E + AS + NAS)				
Year of legalisation	21.4		19.8	13.8
1 year post-	20.5		20.1	19.1
5 years post-	21.2	22.0	20.3	
10 years post-	35.5	33.2**	20.4	
Last recorded	46.3	34.6	25.5	25.7
Growth as %	***116.4%***	***57.3%***	***28.8%***	***86.2%***
	(2002 - 2018)	*(2008- 2016)*	*(2003 - 2018)*	*(2016 - 2019)*

Table 1: European and Canadian summary statistics
Notes:
Euthanasia = 'E', Assisted-suicide = 'AS', Non-assisted suicide = 'NAS'
Suicide rates are not age-standardised and thus represent actual numbers.
Percentage/rate figures have been rounded to 1 decimal place, while growth calculations utilise actual values.
References are provided at the end of this article.
**Reliable data is unavailable for Belgium and Switzerland from the year of legalisation, so the year 2003 was used as a surrogate as this marks the beginning of the reliable data. Additional suicide data limitations regarding Belgium further affected the scope of the displayed figures.*

***Revisory research suggests that in 2013, up to 40% of all euthanasia cases in Belgium were not reported[18]. Therefore, marked figures should be considered low-end estimates.*

Additional Jurisdictional Evidence: Australian and US States

In addition to these four nations, there are a number of states from Australia and the United States that have legalised assisted-suicide and euthanasia. Australians in Victoria have had legal access to assisted suicide since 2019, while Oregon, Washington State and Vermont have all had legalised assisted-suicide / euthanasia for more than 10 years. While reporting data in Vermont is regrettably limited, evidence from Victoria, Oregon and Washington displays a similar pattern to that found in the rest of the world.
This is displayed in Table 2 (below), which shows the total suicide rate (per 100,000 people) for all regions discussed thus far, during the year of legalisation (or the earliest available date near to legalisation) and from the last available date, along with the overall growth of these statistics (as a %). Also included is a global average for each measure which shows the global trend for nations with legalised euthanasia and/or assisted-suicide.

		Total Suicide Rate per 100,000 (E + AS + NAS)		
	Legal Status	Earliest Available (year)	Last Recorded (year)	**Growth as %**
Victoria	VAD legal since 2019 *(data from 2017-2020 for a min 3-year trend)*	10.9 *(2017)*	13.1 *(2020)*	***20.6%***
Oregon	Assisted-suicide legal since 1997*	17.9 *(1998)*	26.0 *(2019)*	***45.3%***
Washington State	Assisted-suicide legal since 2009	14.7 *(2009)*	20.0 *(2018)*	***36.0%***
The Netherlands	Legal since 2002	21.4 *(2002)*	46.3 *(2018)*	***116.4%***
Belgium	Legal since 2002	22.0 *(2008)*	34.6 *(2016)*	***57.3%***
Switzerland	Assisted-suicide de facto legal since 1937 Euthanasia still illegal	19.8 *(2003)*	25.5 *(2018)*	***28.8%***
Canada	Legal since 2016	13.8 *(2016)*	25.7 *(2019)*	***86.2%***
Global Average		*17.2*	*27.3*	***55.8%***

Table 2: Global summary statistics
Notes:
'VAD' = Voluntary Assisted Dying
Suicide rates are not age-standardised and thus represent actual numbers
Percentage/rate figures have been rounded to 1 decimal place, while growth calculations utilise actual values.
References are provided at the end of this article.
**Oregon data begins in 199*

[18] Chambaere et al. (2015)

- **FULL REFERENCES ARE AT THE BACK OF THIS ANALYSIS** -

As noted, Victoria, Oregon and Washington State have all seen similar increases in their total suicide rate (E+AS +NAS), by *20.6%*, *45.3%* and *36%* respectively. **When viewed in sum, after legalising euthanasia and/or assisted suicide, the seven regions show an average growth of *55.8%* in the total rate of suicides performed each year.**

B. Non-assisted Suicide: Increases Following Legalised Euthanasia

The data reveals that the legalisation of E +AS in both the Netherlands and Oregon has lead to an increase in non-assisted suicide rates too. This is illustrated below Table. It shows the Netherlands and Oregon have seen increases in their respective non-assisted suicide rates: from 9.9 to 10.6 per 100,000 and from 17.4 to 21.5 per 100,000 of population.

	Non-assisted Suicide Rate per 100,000 (NAS)	
	Year of legalisation (year)	Last Recorded (year)
The Netherlands	9.9 *(2002)*	10.6 *(2018)*
Oregon*	17.4 *(1998)*	21.5 *(2019)*

Table 3: The Netherlands and Oregon non-assisted suicide rates since legalisation
Notes:
Suicide rates are not age-standardised and thus represent actual numbers
References are provided at the end of this article.
**Oregon data begins in 1998*

In Victoria the non-assisted suicide rate has not decreased by about 50 people per year, following 'VAD' being legalised, as the Health Minister Jill Hennessy said would happen at the time of the debate in 2017[19]. But rather the non-assisted suicide rate increased by 4 people. In 2017 the number of Victorian's that suicided was 694 and in the first 12 months the legislation was in operation the number of Victorian's that suicided (non-assisted) was 698.

QUEENSLAND'S LIKELY INCREASE IN OVERALL SUICIDES IF ASSISTED SUICIDE & EUTHANASIA IS LEGALISED

Empirical evidence indicates that NSW may see an increase in the rate of non-assisted suicides committed each year due to a suicide contagion effect, and it's highly likely there will a marked increase in the total rate of suicidality (E+AS + NAS) every year.

***Note – the below projection done by an economist based on the Queensland suicide rate, we will send the NSW likely projection soon, although the numbers will

[19] Jill Hennessey's claim, reported by the Australian Care Alliance, https://d3n8a8pro7vhmx.cloudfront.net/australiancarealliance/pages/64/attachments/original/1624935082/Social_contagion_of_suicide.pdf?1624935082

vary between the two states the trajectory of the forecast increase would be the same.***
Utilising Queensland's latest available suicide data and the global average increase in total suicide rates from the seven examined jurisdictions (55.8% over an average timeframe of approximately 11 years), Figure 1 (below) illustrates the projected path of Queensland's total suicide rate (E+AS +NAS), should euthanasia be legalised. This is a very sad projection, and for the sake of lives, this legislation must be rejected.

A projection of overall suicide rates should assisted suicide and euthanasia be legalised can be is shown on the next page.

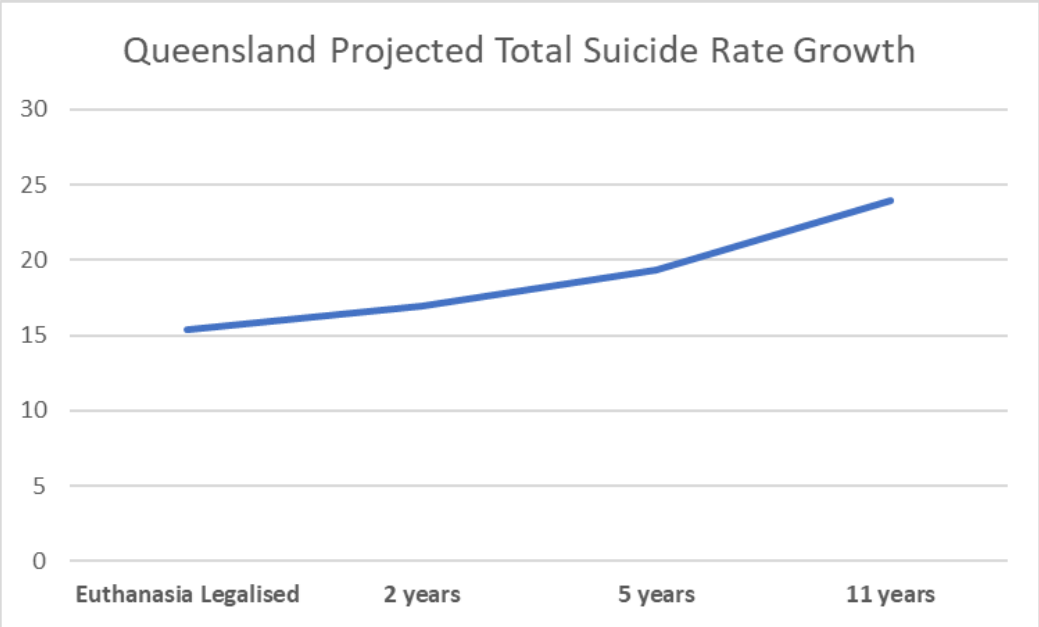

Figure 1: Queensland Projected Total Suicide Rate Growth (per 100,000 of population)

FOOTNOTES

1. Chambaere, K, Stichele, RV, Mortier, F, Cohen, J & Deliens, L 2015, 'Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium', New England Medical Journal, No. 372(12), pp.1179-1181, doi: 10.1056/NEJMc1414527.

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SECTION III: THE NEED FOR EQUITABLE PALLIATIVE CARE INVESTMENT IN NSW

Chronic underfunding and palliative care staff shortages have arguably led to most of the demand for euthanasia and assisted suicide legalisation in this state. It's almost certain that if NSW had a strong, easily-accessed and equitable palliative care system across the state there would be no euthanasia and assisted Bill before Parliament.

Professor Stephen Duckett at the Grattan Institute states:

"..palliative care services throughout Australia are woefully underprovided. People are dying in hospitals when they want to die at home. In addition to being a personal tragedy, under-provision of palliative [care] makes no economic sense." How to improve palliative care - Grattan Institute

The 91 FTE (approx.) palliative care specialists for NSW translates into just 1.1 palliative medicine specialists per 100,000 population. But according to Palliative Care Australia's we need 2 FTE specialist palliative medicine physicians per 100,000 population, meaning NSW needs about double the number of palliative care specialists it currently has.
While this extreme deficit is most felt in regional NSW, there is a lack of palliative care even in major hubs, for example, Westmead Hospital, which services a large part of western Sydney comprising a population of around 2 million people has no dedicated palliative care beds.

For decades different policy reforms and budgets have failed to properly address the palliative care deficit and ensure equitable and timely access to this essential and humane end-of-life specialty care for all NSW residents.

It's time that there is legislation to ensure that all NSW residents have the right access to timely palliative care specialist services, for free, should they need it.

As such would like to see the introduction of a *Palliative Care Equitable Access Bill 2021* or something similar and the rejection of the *Voluntary Assisted Dying Bill 2019* be rejected. Or if tragically the "VAD" Bill is passed, that complementary palliative care legislation is enacted that ensures sufficient and free access to palliative care for all.

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