Submission No 48

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Organisation: Australian Christian Lobby

Date Received: 22 November 2021

SUBMISSION:

New South Wales
Voluntary Assisted Dying Bill 2021

AUSTRALIAN CHRISTIAN LOBBY

About Australian Christian Lobby

Australian Christian Lobby's vision is to see Christian principles and ethics influencing the way we are governed, do business, and relate to each other as a community. ACL seeks to see a compassionate, just and moral society through having the public contributions of the Christian faith reflected in the political life of the nation.

With more than 160,000 supporters, ACL facilitates professional engagement and dialogue between the Christian constituency and government, allowing the voice of Christians to be heard in the public square. ACL is neither party-partisan nor denominationally aligned. ACL representatives bring a Christian perspective to policy makers in Federal, State and Territory Parliaments.

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22 November 2021

Dear Sir/Madam

On behalf of the Australian Christian Lobby (ACL), thank you for the opportunity to make a submission on the *Voluntary Assisted Dying Bill* (NSW).

Please find attached our submission on this important issue.

I am available to discuss any issues which may arise from this submission.

Yours sincerely,

Wendy Francis
National Director / Politics

INTRODUCTION

This submission addresses the fundamental flaws in the proposed *Voluntary Assisted Dying Bill 2021* (NSW) (the **Bill**). The Australian Christian Lobby (the **ACL**) is opposed to any laws that sanction the killing of the sick, the elderly and the vulnerable. This Bill is the most extreme of its kind in Australia and seeks to introduce access to state sanctioned suicide in a way that is far more concerning than similar laws introduced in other states. The flaws in this Bill are enough to render the Bill too dangerous to be passed and the ACL submits that the Bill should be rejected in its entirety.

The ACL is committed to the dignity and wellbeing of the elderly, the sick and the vulnerable. That is why we strongly support improvement of the quality and access to world-class palliative care.

EXECUTIVE SUMMARY

The Bill fails to provide adequate safeguards for the terminally ill and vulnerable, nor does it sufficiently protect people or entities that are conscientiously opposed to state-assisted suicide.

Below are the key failings of the Bill:

1. The Bill undermines the importance of palliative care. A person should not be able to access voluntary assisted dying (**VAD**) unless they have first exercised their right to palliative care;
2. The Bill doesn't protect health care workers. A religious health care worker who has a conscientious objection to VAD should not have to participate in any part of the VAD process, including referrals;
3. The Bill fails to protect health care workers from regulatory punishment. A conscientious objector's choice not to participate in VAD should be irrelevant to any consideration about the person's conduct or performance under other health legislation;
4. The Bill doesn't protect faith-based hospitals and organisations. The Bill requires faith-based organisations to act contrary to their conscientious position and their faith-based objects. Faith-based organisations should be able to refuse to participate in every aspect of the VAD process, including providing access to information about VAD;
5. The Bill fails to protect faith-based organisations from regulatory punishment. The mere fact that a faith-based hospital or facility does not participate in the VAD process should not be the subject of a health service complaint;
6. The Bill does not protect the mentally unwell and vulnerable. No-one should be able to access VAD without first having a mental health assessment by a psychologist to exclude any undiagnosed mental illness or distress;
7. A health care worker can initiate a conversation about VAD. A health care worker should never be able to discuss VAD except at the request of a patient;
8. The Bill does not require expert and quality medical care for the vulnerable. At the very least a coordinating practitioner should have 10 years' clinical experience and an existing doctor/patient relationship with the patient. Any consulting practitioner should have at least 10 years' clinical experience in the disease, illness or medical condition suffered by the patient. A coordinating practitioner and consulting practitioner should be independent from each other;

9. The Bill fails to provide an adequate period before allowing people to commit suicide. There needs to be a mandatory cooling off period of at least 14 days before a person may follow through with taking the VAD substance;
10. The Bill tries to cover up that someone has committed suicide. If someone takes a VAD substance to die, their death certificate should record that fact.

SPECIFIC SUBMISSIONS

We set out below our submissions on the failures of the Bill. We identify safeguards and protections that are missing which should in no way be taken to be an approval of the Bill even if all missing safeguards and protections are addressed. The Bill is still fundamentally flawed and should be rejected.

Clause 4 – Principles

Paragraph 4(1)(c) should be amended to require that a person **must** be given, in a way the person understands, information about medical treatment options etc. Merely providing that a person *should* be given such information is too aspirational.

Paragraph 4(1)(d) should be revised so that a person approaching the end of their life **is to be** provided with high quality care and treatment. Merely providing that these persons *should* be provided with high quality care and treatment implies tolerance of a lower standard, which is not acceptable.

Paragraph 4(1)(h) should be expanded to cover similar matters to paragraph (1)(k), so that a person is entitled to genuine choices about the person's care, treatment and end of life …. having regard to the person's culture, **religion, beliefs, values and** language.

Paragraph 4(1)(i) should be amended to refer to access to **healthcare**, rather than voluntary assisted dying. Regional residents should have the same level of access to healthcare as those in metropolitan regions.

Clause 6 – Decision-making capacity

Subclause 6(2) should be removed. Given the gravity of the decision, nothing should be presumed about the patient or their circumstances.

Subclause 6(2) states that:

1. a patient is presumed to have the capacity to understand information or advice about voluntary assisted dying if it reasonably appears that the patient is able to understand an explanation of the consequences of making the decision, and
2. a patient is presumed to have decision-making capacity in relation to voluntary assisted dying unless the patient is shown not to have the capacity.

It is unclear who bears the onus of showing that the patient does not have decision-making capacity and, even if this were shown, whether this could be disregarded by a coordinating practitioner or consulting practitioner with a difference of opinion.

This clause should also be amended to specifically state that a patient with a disability or mental health impairment (within the meaning of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020*) is taken to lack decision-making capacity (see our comments on subclause 16(2) below).

Clause 9 – Registered health practitioner may refuse to participate in voluntary assisted dying

Subclause 9(1) allows a registered health practitioner who has a conscientious objection to refuse to do various things relating to the voluntary assisted dying process. Despite subclause 9(2), subclause 9(1) should be amended specifically to allow a registered health practitioner to refuse to:

1. provide information to a person about voluntary assisted dying; and
2. participate in an administration decision (cf paragraph 89(2)(b) in relation to residential facilities and health care establishments).

If a registered health practitioner has a conscientious objection, the practitioner should not be required to assist a person in relation to the process at all. A person who truly wants information or to make a request under the voluntary assisted dying process will not be deterred by a practitioner who exercises a conscientious objection. Rather, the person will seek out a practitioner that does not have such an objection.

Clause 9 should also be further amended to ensure that practitioners who exercise these rights do not face any discrimination for doing so, particularly in relation to the renewal of their registration or future employment decisions. Discriminatory actions should be subject to a criminal penalty. See also our comments on clause 11 below.

Part 4 – Division 1 – new provision

This Part sets out the requirements that must be met for a person to be eligible to act as an administering practitioner for a patient.

This Part should be amended to provide an interpreter with the same rights as a registered health practitioner to refuse to participate in various steps in the voluntary assisted dying process.

This Part should also be further amended to ensure that interpreters who exercise these rights do not face any discrimination for doing so, particularly in relation to the renewal of their registration or future employment decisions. Discriminatory actions should be subject to a criminal penalty.

Clause 10 – Health care worker not to initiate discussion about voluntary assisted dying

Subclauses 10(2) and 10(3) should be removed, ensuring that the heading to the clause is accurate. The only circumstance in which a medical practitioner or another health care worker should be legally allowed to discuss voluntary assisted dying with a person is at the person's request. Subclause 10(2) allows a medical practitioner to initiate a discussion about, or suggest, voluntary assisted dying if the worker also informs the person about treatment options and palliative care available to the person. Subclause 10(3) allows a health care worker to initiate a discussion about, or suggest, voluntary assisted dying if the worker also informs the person that palliative care and treatment options are available and that these should be discussed with the person's medical practitioner.

When providing a health service or professional care service, a medical practitioner and other health care workers should focus on providing the best level of service to the person, identifying and treating the person's symptoms and respecting the inherent dignity of the person. This would accord with the principles stated in the Bill, particularly those set out in paragraphs 4(a), (b) and (d).

To avoid any doubt, clause 10 should also be amended to ensure that subclause (5) (about the initiation of discussions by a disability care provider) is subject to clause 124 (inducing another person to request or access voluntary assisted dying).

Clause 11 – Contravention of Act by registered health practitioner

This clause should be amended to specifically state that, despite subclause 11(1), the mere fact that a registered health practitioner exercised their right to refuse to participate in any aspect of the voluntary assisted dying process under clause 9 is irrelevant to any consideration about the person's professional conduct or performance.

To avoid any doubt, clause 11 should be amended to ensure that subclause (1) is subject to Part 7 (offences). Subclause (2) should be amended to provide that "subsection (1) applies **even if** the contravention constitutes an offence under this Act", recognising that a contravention may constitute both an offence and a breach of the national law.

The relationship between clause 11 and clause 137 should also be clarified. It is unclear which provision applies to a registered health practitioner who acts in good faith and with reasonable care and skill if such action nonetheless contravenes the Act.

Clause 12 – Voluntary assisted dying not suicide

This clause should be removed. Stating that a person who dies as the result of the administration of a prescribed substance does not die by suicide is inaccurate and dishonest. If a person dies as a result of the provision of assisted dying, the person dies intending to cause their own death and the law should acknowledge the truth of what it has allowed to take place.

Clause 16 – Eligibility criteria

The eligibility criteria should be amended so that a person is ineligible for access to voluntary assisted dying if the person has not first been informed and tried palliative care, or other medical treatments intended to relieve pain and distress.

If a person receives care focussed on symptom relief, the prevention of suffering and an improvement of quality of life, they may no longer have any desire to seek access to voluntary assisted dying. The ACL notes the AMA's position that doctors have a responsibility to initiate and provide good quality end of life care.

The eligibility criteria should be further amended so that a person is ineligible for access to voluntary assisted dying unless the person has, within the month before a first request is made, had a mental health assessment by a psychologist, ensuring that the person is not suffering from any undiagnosed mental illness or distress affecting their ability to request voluntary assisted dying.

Virtually all people facing death or battling an irreversible, debilitating disease suffer depression at some point. Overseas experience shows that requests for assisted dying are revoked if a person's depression and pain are satisfactorily treated.

The Bill provides that a person's disease, illness or medical condition must be expected to cause death within 6 months, unless the disease, illness or medical condition is neurodegenerative, in which case, the period is 12 months (subparagraph 16(1)(d)). This distinction should be removed and the period (within which death is expected to occur) standardised to 12 months. This would be consistent with the recently passed *Voluntary Assisted Dying Act 2021* (Qld).

Subclause 16(2) is clumsily drafted. It should be removed and clause 6 should be amended to specifically state that a person with a disability or mental health impairment is taken to lack decision-making capacity. See further our comments on clause 6 above.

Clause 17 – Residency exemptions

One of the criteria for eligibility for access to voluntary assisted dying is that the person is ordinarily resident in New South Wales for a period of at least 12 months. Subclause 17(2) *requires* the Board to grant an exemption from this requirement if the person has a substantial connection to New South Wales and there are compassionate grounds for granting the exemption.

This clause should be removed. Its application is unclear. What is a substantial connection to New South Wales? The examples set out under paragraph 17(2)(a) provide inadequate guidance to the Board. Is the fact that a person, at some time in their life, owned property in New South Wales and regularly holidayed there enough to establish a substantial connection? This vagueness is inappropriate for an exemption the Board must grant.

Clause 18 – Eligibility to act as coordinating practitioner or consulting practitioner

A person is able to act as coordinating practitioner or consulting practitioner for a patient without sufficient experience and without any expertise in the disease, illness or medical condition suffered by the patient. This is unacceptable.

Clause 18 should be amended to require:

1. a coordinating practitioner to have at least 10 years' clinical experience; and
2. a coordinating practitioner to have an existing doctor/patient relationship with the patient, unless the practitioner has a conscientious objection; and
3. a consulting practitioner to have at least 10 years' clinical experience in the disease, illness or medical condition suffered by the patient; and
4. a coordinating practitioner and consulting practitioner to be independent of each other.

Further, if an overseas-trained specialist, the practitioner should not be eligible to act as a coordinating or consulting practitioner if the practitioner only holds limited or provisional registration.

Clause 19 – Person may make first request to medical practitioner

Under subclause 19(3) a person may make a request for access to voluntary assisted dying verbally or in another way, such as by gestures.

The ability to make a request by gestures leaves too much scope for misinterpretation and should be removed. Suppose a person points two fingers to their head to indicate shooting themselves in the head. While this may be interpreted as a clear and unambiguous sign that the person is requesting access to voluntary dying, it may in fact be expressing frustration with family members or with the level of care being provided to the person.

If the person is unable to make a request verbally or by some other means of communication (eg using Auslan), how can it be established that a person truly has decision-making capacity?

Any reference to allowing a person to communicate by gestures should be removed from the Bill (clauses 48, 57 and 58 also refer).

Further, a person should not be able to make a request using audio-visual communication. See also our comments on clause 182.

Clause 23 – Medical practitioner to notify Board of first request

Clause 23 requires a medical practitioner to give a completed first request form to the Board within 5 days of deciding to accept or refuse a first request. If a medical practitioner refuses a request, the reason for doing so must be included in the form (paragraph 23(2)(h) refers).

Paragraph 23(2)(h) should be deleted. Subclause 21(2) sets out the only grounds on which a request may be refused. There is no reason why the Board needs to be informed which ground applies; it is not relevant to their functions. This is administrative overreach.

Clause 25 – First assessment

Clause 18 should be amended to require the coordinating practitioner to possess appropriate levels of experience, as recommended above.

The coordinating practitioner for a patient must assess whether or not the patient is eligible for access to voluntary assisted dying. It is noted that some eligibility criteria, such as evidence of decision-making capacity, may require legal or legal-medico expertise rather than medical expertise.

But more concerningly, this assessment could be made by a practitioner without an existing doctor/patient relationship with the person, or a practitioner lacking any significant medical expertise or clinical experience. The coordinating practitioner need not be a practitioner that specialises in the person’s underlying disease, illness or medical condition. Even if a specialist, the practitioner need only have a years’ experience as a specialist. This is unacceptable.

The expertise of another, by a referral under clause 26, is not sought unless the coordinating practitioner is unable to assess whether the person is eligible for access to voluntary assisted dying.

Clause 26 – Referral to another medical practitioner for opinion–disease, illness or medical condition

If the coordinating practitioner for a person is unable to assess whether or not the person has a disease, illness or medical condition that meets the requirements of paragraph 16(1)(d), the coordinating practitioner must refer the person to a registered health practitioner or another person (the ***referee***) who has the appropriate skills and training to determine the matter. However, the coordinating practitioner is *not* required to adopt the referee's assessment of the matter, even though the coordinating practitioner was unable to assess the matter him or herself.

Clause 26 should be amended to:

1. enable the coordinating practitioner to refer the matter of whether the person has a disease, illness or medical condition that meets the requirements of paragraph 16(1)(d) to a referee once (to avoid any ability for opinion shopping);
2. require the process to end if the coordinating practitioner does not adopt the referee's assessment;
3. update the section heading accordingly.

Clause 27 – Referral for opinion–other matters

If the coordinating practitioner for a patient is unable to assess whether or not the patient has decision-making capacity, or is acting voluntarily, or is not acting because of pressure or duress (the ***referral matters***), the coordinating practitioner must refer the patient to a psychiatrist or another registered health practitioner (the ***referee***) who has the appropriate skills and training to determine the matter. However, the coordinating practitioner is *not* required to adopt the referee's assessment of the matter, even though the coordinating practitioner was unable to assess the matter him or herself.

Clause 27 should be amended to:

1. enable the coordinating practitioner to refer each referral matter to a referee once (to avoid any ability for opinion shopping), allowing a maximum of 3 referrals under this clause per patient;
2. require the process to end if the coordinating practitioner does not adopt the referee's assessment on any matter;
3. update the section heading accordingly.

Clause 28 – Information to be provided if patient assessed as meeting eligibility criteria

Paragraph 28(1)(b) requires a coordinating practitioner to inform the patient about treatment options that would be considered standard care for the disease, illness or medical condition with which the patient has been diagnosed. Consistently with the principles set out in clause 4, paragraph 28(1)(b) should be amended to refer to **optimal care** rather than standard care. The principle set out in subclause 4(d) refers to a person approaching end of life being provided with "high quality care and treatment" which contemplates an approach to care beyond what is standard.

Paragraph 28(1)(c) requires a coordinating practitioner to inform the patient about palliative care and treatment options. Consistently with our comments on clause 16 (eligibility criteria), a patient would be ineligible for access to voluntary assisted dying if the patient had not first tried palliative care, or other treatment options intended to relieve pain and distress, obviating the need to inform the patient. The ACL notes once again the AMA's position that doctors have a responsibility to initiate and provide good quality end of life care.

If a patient makes a request for access to voluntary assisted dying to a medical practitioner who is not their usual treating practitioner, subparagraph 28(1)(j)(i) encourages the patient to inform the treating practitioner of their request. Subparagraph 28(1)(j)(i) should require:

1. the coordinating practitioner to inform the treating practitioner of the patient's request for access to voluntary assisted dying; and
2. the coordinating practitioner to inform the patient that the practitioner is required to inform the patient's treating practitioner of the request. This is important as the treating practitioner could have information relevant to the patient's request.

Subparagraphs 28(1)(j)(ii) and (iii) should be removed. A treating practitioner should be able to withdraw services to a patient if a request for voluntary assisted dying would compromise the care provided to the patient (for example, the ceasing of medication that might interfere with the efficacy of a prescribed substance).

Subparagraph 28(1)(j)(ii) also provides that it is unlawful for a treating practitioner to withdraw services to the patient's family or other close contacts. This is unnecessary. A medical practitioner treats each person according to their individual health needs and it is offensive to suggest otherwise.

Clause 30 – Recording and notification of outcome of first assessment

Paragraph 30(4)(g) requires the first assessment form to include the outcome of the first assessment, including the coordinating practitioner's decision about each of the eligibility criteria. If the coordinating practitioner referred a matter for an opinion under clause 26 or 27, or both, and did not adopt the opinion of the referee, the coordinating practitioner should be required to give reasons why the referee's opinion was not adopted. Paragraph 30(4)(g) should be amended accordingly.

Clause 34 – Medical practitioner to notify Board of referral

Clause 34 requires a medical practitioner to give a completed consultation referral form to the Board within 5 days of deciding to accept or refuse a referral. If a medical practitioner refuses a referral, the reason for doing so must be included in the form (paragraph 34(2)(f) refers).

Paragraph 34(2)(f) should be deleted. Subclause 32(2) sets out the only grounds on which a referral may be refused. There is no reason why the Board needs to be informed which ground applies; it is not relevant to their functions. This is administrative overreach.

Clauses 37 and 38 – Referral to another medical practitioner for opinion

If the coordinating practitioner assesses the patient as meeting the requirements of the first assessment, the practitioner must refer the patient to another medical practitioner for a consulting assessment (clause 31). The second medical practitioner (the ***consulting practitioner***) must independently assess whether the patient is eligible for access to voluntary assisted dying. The referral process described above applies in relation to the coordinating practitioner. It suffers from the same flaws as clauses 26 and 27.

Clauses 37 and 38 should be amended so that the process ends if:

1. the same referral matter is referred to a referee under both the first assessment and the consulting assessment (there is clearly an issue if a matter relating to eligibility requires the opinion of 4 persons and over which opinion could be equally divided 2:2); or
2. the coordinating practitioner does not adopt the consulting practitioner's assessment of any matter referred.

Clause 41 – Recording and notification of outcome of consulting assessment

Paragraph 41(4)(g) requires the consulting assessment form to include the outcome of the consulting assessment, including the consulting practitioner's decision about each of the eligibility criteria. If the consulting practitioner referred a matter for an opinion under clause 37 or 38, or both, and did not adopt the opinion of the referee, the consulting practitioner should be required to give reasons why the referee's opinion was not adopted. Paragraph 41(4)(g) should be amended accordingly.

Clause 42 – Referral for further consulting assessment if patient assessed as ineligible

If the consulting practitioner assesses the patient as ineligible, the coordinating practitioner may refer the patient to another medical practitioner for a further consulting assessment. The Bill does not limit the number of times a further consulting assessment can occur.

Clause 42 should be removed. If the consulting practitioner assesses the person as ineligible, the Bill should state that the process ends.

Allowing for further consulting assessments enables the perverse result that a person may be eligible for access to assisted dying even if more medical practitioners do not consider the person to have met at least one eligibility criterion than those that do. Consider, for example:

1. a person is assessed as meeting the requirements of the first assessment (despite the coordinating practitioner not adopting a referee's determination of a matter);
2. a person is assessed as being ineligible by a consulting practitioner (whether or not any matters were referred to a referee for determination);
3. a further consulting practitioner assesses the person as ineligible (whether or not any matters were referred to a referee for determination);
4. a further consulting practitioner assesses the person as eligible.

In these circumstances, 5 practitioners considered a person's eligibility, or at least one aspect of a patient's eligibility, for access to voluntary assisted dying. Three practitioners did not consider that at least one eligibility criterion was satisfied, but the patient will be eligible for voluntary assisted dying based on the assessment of 2 practitioners; their opinion effectively outweighing the contrary opinion of 3 practitioners. This is nonsensical.

Clause 43 – Patient assessed as eligible may make written declaration

Subclause 43(4) sets out who may sign a written declaration on behalf of a patient. Subclause 43(4) should be amended so that, in addition to the criteria set out in paragraph (4)(c), the person must not be someone in respect of whom any of paragraphs 44(2)(a) to (d) could be satisfied (relating to ineligible witnesses). This means that, apart from being an adult and not being a witness to the signing of the declaration, the person:

1. is not someone who may benefit financially from the patient's death; or
2. is not a family member of the patient; or
3. is not the coordinating practitioner or consulting practitioner for the patient; or
4. is not a family member or employee of the coordinating practitioner or consulting practitioner for the patient.

If the person makes a written declaration with the assistance of an interpreter, the interpreter must certify on the declaration that the interpreter provided a true and correct translation of any material translated. The Bill should be amended to provide for a penalty if the interpreter does not do so. If the Bill does not require or provides no sanctions in relation to the integrity of persons involved in the process, a person making a decision with irreversible consequences is not adequately protected.

Clause 48 – Patient may make final request to coordinating practitioner

A patient should not be able to make a final request using gestures or audio-visual communication. See our comments on clause 182.

Clause 49 – When final request may be made

Subclause 49(2) allows the person to make a final request before the end of 5 days after the person's first request if the coordinating practitioner considers that the person is likely to die, or lose decision-making capacity, before the end of that period and that opinion is consistent with the consulting practitioner's assessment.

Subclause 49(2) should be removed from the Bill. If a person is likely to die or lose decision-making capacity before the end of 5 days after the person's first request, the person is not in need of assistance to die sooner.

Clause 52 – Final review by coordinating practitioner on receiving final request

The Bill provides that a patient may, at any time, decide not to take any further steps in the process, even if after the request and assessment process has ended (clause 54). Clause 52(4) should be amended to require:

1. the coordinating practitioner to give a copy of the final review form to the patient (within 5 business days of the form being completed); and
2. the coordinating practitioner to inform the patient that the patient may, at any time, decide not to take any further steps in the process, even if after the request and assessment process has ended.

Further, there should be a criminal penalty if the coordinating practitioner fails to do either or both of these things.

Clause 53 – Technical error not to invalidate request and assessment process

This clause should be removed. Given the nature of the decisions being made under this legislation, nothing less than strict compliance with the law should be required.

Clause 55 – Eligibility requirements for administering practitioners

Clause 55 sets out the eligibility requirements for administering practitioners. These requirements should not be less stringent than the eligibility requirements for coordinating practitioners, and clause 55 should be amended to align the eligibility requirements for administering practitioners with those for coordinating practitioners (see our comments on clause 18 above).

Part 4 – Division 2 – Administration of voluntary assisted dying substance

This Division should be amended to include a mandatory cooling-off period of 14 days before a patient may self-administer, or have administered, a prescribed substance. This is consistent with the law in Victoria and overseas (the law in Oregon, USA requires a 15 day cooling-off period, with limited exceptions, and Canadian legislation provides for a 10 day cooling-off period).

Clause 58 – Revocation of administration decision

If a patient makes an administration decision, that is, decides to self-administer, or have administered, a voluntary assisted dying substance, and subsequently revokes the decision, subclause 58(7) provides that a patient is not prevented from making an administration decision again.

However, the Bill should be amended to require a new request and assessment process at the end of 3 months after the patient first makes an administration decision. Hesitation in carrying out an administrative decision indicates that despite the patient making requests and going through the assessment process, the patient is having second thoughts and not committed to their initial decision.

Clause 59 – Self-administration

Subclauses 59(7) should be amended to clarify that the supply of the prescribed substance to the patient is for the patient to self-administer the substance.

Clause 61 – Coordinating practitioner to notify Board about prescription of substance

Subclause 61(2) should be amended to require the prescription form to include the name and contact details of the authorised supplier to whom the prescription was given (cf subclause 74(5)).

Clause 63 – Witness to administration of prescribed substance

The Bill does not preclude the same person from both witnessing the administration of a prescribed substance by an administering practitioner and witnessing the signing of a patient's written declaration (clause 44 refers). To ensure greater checks in the process, the Bill should be amended to ensure that the same person cannot carry out both roles.

Further, the grounds which preclude a person from witnessing the administration of a prescribed substance are narrower than those that preclude a person from witnessing the signing of a patient's written declaration. Subclause 63(3) should be amended so that the grounds are aligned. A person should be precluded from being a witness if the person:

1. is someone who may benefit financially from the patient's death; or
2. is a family member of the patient; or
3. is the coordinating practitioner, consulting practitioner or administering practitioner for the patient; or
4. is a family member or employee of the coordinating practitioner, consulting practitioner or administering practitioner for the patient.

Clause 64 – Transfer of administering practitioner's role

Clause 64 should be amended to clarify that subclause (2) is subject to clause 9 (registered health practitioner may refuse to participate in voluntary assisted dying).

Clause 68 – Role of contact person

Clause 68 authorises a contact person to take certain actions.

Paragraph 68(1)(c) should be removed. A contact person should not be authorised to prepare the prescribed substance for self-administration by the patient. If the prescribed substance needs to be prepared, that kind of substance is not suitable for self-administration. The coordinating practitioner should take this into account when discussing administration decisions with the patient and prescribing the prescribed substance.

Paragraph 68(1)(d) should be amended to clarify that the supply of the prescribed substance by the contact person is for the patient seeking voluntary assisted dying to self-administer the substance.

Clause 69 – Contact person may refuse to continue in role

Clause 69 should be amended to *require* a contact person to give a prescribed substance to an authorised disposer if the contact person refuses to continue in the role but remains in possession of the substance. Such action is not contemplated under clause 68 or 129. Such amendment is necessary to ensure that the substance is not used in another situation without lawful authority. The Bill should include a criminal penalty for a failure to do so.

Clause 70 – Information to be given when supplying prescribed substance

Subclause 70(2) should be amended to require an authorised suppler to inform the recipient, in writing, of the Schedule 4 poison or Schedule 8 poison that is supplied.

Clause 73 – Information to be given before prescribing substance

Subclause 73(3) should be amended to require the coordinating practitioner for the patient to inform the patient, in writing, of the ways in which the person may revoke the patient's administration decision.

Clause 75 – Authorised supplier to authenticate prescription

There is no penalty if an authorised supplier fails to authenticate a prescription as required by clause 75. The Bill should be amended to correct this oversight.

Clause 79 – Storage of voluntary assisted dying substance

There is no penalty if a person who receives a voluntary assisted dying substance fails to store the substance in a locked box. Given the potential consequences of such a failure, the Bill should be amended to include a criminal penalty for failing to store the substance as required.

Clause 84 – Authorised suppliers and authorised disposers

This clause should be amended to specifically exclude a person who would otherwise fall within a class of registered health practitioners authorised to supply or dispose of prescribed substances for the purposes of this Part if the person has a conscientious objection and does not wish to participate in any step relating to the preparation, supply or disposal of a prescribed substance.

Clause 85 – Certain directions as to supply or administration prohibited

Clause 85 prohibits a patient's coordinating practitioner from directing a health professional to supply a prescribed substance to certain persons unless the health professional is an authorised supplier and the direction is given in the form of a prescription. The clause should be amended to provide a criminal penalty for a coordinating practitioner who contravenes the prohibition, otherwise the clause should be removed.

Clause 86 – Structured administration and supply arrangement not to be issued for substance

Clause 86 prohibits a person from issuing a structured administration and supply arrangement in relation to the administration or supply of a medicine for the purpose of voluntary assisted dying. The clause should be amended to provide a criminal penalty for a person who contravenes the prohibition, otherwise the clause should be removed.

Part 6 – Division 1 – Participation

Clause 89 – Participation in providing voluntary assisted dying services

Clause 89 allows a residential facility or health care establishment to decide not to provide services relating to voluntary assisted dying at the facility or establishment. However, this provision is subject to Divisions 2 and 3, which requires these facilities and establishments to allow reasonable access to persons involved in the voluntary assisted dying process and to require residents to be transferred for such purposes, rendering the provision meaningless. To correct this, subclause 89(3) should be amended to ensure that subsections (1) and (2) are ***not*** subject to the requirements to Divisions 2 and 3.

Alternatively, more specific amendments to these Divisions should be made, as set out below.

Part 6 – Division 2 – Residential facilities

This Division should be amended to exclude faith-based residential facilities. Providing voluntary assisted dying, and enabling any step in the voluntary assisted dying process, is precluded by the ethos of such residential facilities.

This Division should be amended so that faith-based residential facilities are not required to:

1. allow reasonable access to a medical practitioner, whether a coordinating practitioner or otherwise; or
2. take reasonable steps to facilitate the transfer of a person for the purposes of taking any step in the voluntary assisted dying process (cf clauses 92 to 96).

Alternatively, if this approach is not accepted, Division 2 should be amended so that faith-based facilities:

1. are not compelled to act, actively or passively, to facilitate any step of the voluntary assisted dying process; but
2. may not prevent a resident from leaving their premises to take such a step.

This will enable faith-based residential facilities to deliver care to patients in ways that accord with their mission and values but will not prevent a resident from carrying out a step of the voluntary assisted dying process elsewhere.

It is noted that if a resident in such a facility should wish to access voluntary assisted dying, the resident is able to contact the official voluntary assisted dying care navigator service (clause 185).

Clause 97 requires a residential facility:

1. to allow reasonable access to persons participating in the voluntary assisted dying process for the purposes of administering, of facilitating the self-administration of, a voluntary assisted dying substance; and
2. to take reasonable steps to facilitate the transfer of a person for the purposes of enabling a voluntary assisted dying substance to be administered or self-administered.

Clause 97 should be removed. Instead, it should be replaced by a provision making it illegal for a voluntary assisted dying substance to be on the premises of a faith-based residential facility, supported by a criminal penalty for any person who brings a voluntary assisted dying substance onto such premises.

Clause 98 requires relevant entities to publish information about the non-availability of voluntary assisted dying services by such entities. This provision is supported if Division 2 is amended as set out above. However, if Division 2 remains in its current form, clause 98 is unnecessary; relevant entities are required to take a range of actions to ensure residents can access voluntary assisted dying.

Part 6 – Division 3 – Health care establishments

Division 3 applies to health entities in the same way as Division 2 applies to relevant entities. It suffers from the same flaws as Division 2 and should be amended to exclude health entities that are faith-based hospitals or hospices. Providing voluntary assisted dying and enabling any step in the voluntary assisted dying process is precluded by the ethos of such entities.

This Division should be amended so that faith-based health entities are not required to:

1. allow reasonable access to a medical practitioner, whether a coordinating practitioner or otherwise; or
2. take reasonable steps to facilitate the transfer of a person for the purposes of taking any step in the voluntary assisted dying process (cf clauses 101 to 105).

Alternatively, if this approach is not accepted, Division 3 should be amended so that faith-based health entities or health care establishments:

1. are not compelled to act, actively or passively, to facilitate any step of the voluntary assisted dying process; but
2. may not prevent a patient from leaving their premises to take such a step.

This will enable faith-based health entities and health care establishments to deliver care to patients in ways that accord with their mission and values but will not prevent a patient from carrying out a step of the voluntary assisted dying process elsewhere.

It is noted that if a person in a health care establishment should wish to access to voluntary assisted dying, the person is able to contact the official voluntary assisted dying care navigator service (clause 185).

Clause 106 requires a health entity:

1. to allow reasonable access to persons participating in the voluntary assisted dying process for the purposes of administering, of facilitating the self-administration of, a voluntary assisted dying substance; and
2. to take reasonable steps to facilitate the transfer of a person for the purposes of enabling a voluntary assisted dying substance to be administered or self-administered.

Clause 106 should be removed. Instead, it should be replaced by a provision making it illegal for a voluntary assisted dying substance to be on the premises of a faith-based health entity, supported by a criminal penalty for any person who brings a voluntary assisted dying substance onto such premises.

Clause 107 requires health entities to publish information about the non-availability of voluntary assisted dying services by such entities. This provision is supported if Division 3 is amended as set out above. However, if Division 3 remains in its current form, clause 107 is unnecessary; health entities are required to take a range of actions to ensure persons can access voluntary assisted dying.

Clause 109 – Application for review of certain decisions by Supreme Court

Clause 109 allows certain decisions by a patient's coordinating practitioner or consulting practitioner to be reviewed by the Supreme Court. However:

1. decisions relating to some eligibility criteria that must be met for a person to be eligible for access to voluntary assisted dying, such as whether a person has a disease, illness or medical condition that is advanced, progressive and will cause death, are not reviewable; and
2. decisions relating to eligibility criteria that are reviewable if made by the patient's coordinating practitioner are not reviewable when made by a psychiatrist or another registered health practitioner because of a referral (clause 27 refers); and
3. decisions relating to eligibility criteria that are reviewable if made by the patient's consulting practitioner are not reviewable when made by a psychiatrist or another registered health practitioner because of a referral (clause 38 refers).

Clause 109 should be amended to allow review of **all** decisions made relating eligibility criteria, whether made by a patient's coordinating practitioner or consulting practitioner, and whether made by a psychiatrist or another registered health practitioner under a referral. If the latter decisions are excluded, it would be possible for 2 registered health practitioners to work in concert to make decisions relating to eligibility criteria that would always be beyond the purview of the Supreme Court because the decisions were made on referral. This is ludicrous.

Clause 113 – Decision of Supreme Court

Expanding the decisions reviewable by the Supreme Court, as mentioned above, will require clause 113 to be expanded correspondingly.

Clauses 114 and 115 – Effect of decisions under s 113

Expanding the decisions reviewable by the Supreme Court, as mentioned above, will require the circumstances relating to reviewed decisions set aside by the Supreme Court under clauses 114 and 115 to be expanded correspondingly.

Clauses 118 and 119 – Notice requirements and Supreme Court to be given relevant material

Expanding the decisions reviewable by the Supreme Court, as mentioned above, will require the persons to whom notice must be given under clause 118 to be expanded correspondingly, and will require clause 119 to be amended to require such persons to give material to the Supreme Court. Similar consequential amendments will be required for clauses 120 and 121.

Part 7 – Offences: new clause – falsifying documents

Clause 126 creates an offence for making a statement or giving information that a person knows is false or misleading. In addition to this, another offence should be included that specifically prohibits a person from falsifying a form or document required to be made or given under the Act. It is unclear that this is covered by clause 126 and, given the nature of the documents generated during the voluntary assisted dying process and their evidence of life changing decisions, it should be a criminal offence to falsify such a form or document.

Clause 124 – Inducing another person to request or access voluntary assisted dying

The offence of dishonestly, or by pressure or duress, inducing another person to request or access voluntary assisted dying should not be an indictable offence triable summarily. The summary conviction penalty should be removed.

Clause 130 – Recording, use or disclosure of information

This clause prohibits the recording, use or disclosure of information obtained during the course of exercising functions under this Act. An exception exists if the recording, use or disclosure of the information is with the written consent of an executor or administrator of the estate of the person to whom the information relates. This exception should be removed. The only person who should be able to provide written consent to the recording, use or disclosure of information is the person to whom the information relates. If that person has died as a result of being administered, or self-administering, a voluntary dying substance, the information should not be able to be recorded, used or disclosed, except as allowed by clauses 176 and 179 (relating to the collection of statistical information and annual reporting, respectively).

Clause 131 – Publication of personal information concerning proceeding before Supreme Court

This clause prohibits personal information being published about certain persons in relation to a proceeding under Part 6. For example, if the coordinating practitioner or consulting practitioner is not a party to the proceeding, a newspaper article could not name the relevant practitioner.

Clause 131 should be removed. In the interests of transparency, such individuals should be able to be named. Just as residential entities and health entities are required to publish information about the non-availability of voluntary assisted dying services by such entities, information should be publishable about those who are prepared to participate in the voluntary assisted dying process. Publication will allow consumers to make informed choices about whether they wish to seek the services of named individuals in relation to other matters.

Clause 134 – Who may commence proceedings for simple offence

Clause 134 provides that only the Health Secretary, or a person authorised by the Health Secretary, may commence a prosecution for an offence under the Act. This clause should be removed. The role of the NSW Office of the Director of Public Prosecutions is to prosecute crimes under NSW law on behalf of the community. This Office should be responsible for commencing prosecutions for offences under the Act.

Clause 135 – Time limit for prosecution of offence

Clause 135 sets out a time limit for prosecuting an offence, generally prosecutions must be commenced within 2 years of the offence being committed or coming to the attention of authorities. This clause should be removed. This will maintain consistency with similar offences relating to homicide and assisted suicide, which do not contain any limitation periods for commencing prosecutions.

Clause 136 – Protection for persons assisting access to voluntary assisted dying or present when substance administered

Clause 136 provides that a person is not criminally liable if:

1. the person, in good faith, helps another person to request access to voluntary assisted dying; or
2. the person is present when another person self-administers, or is administered, a prescribed substance.

This clause should be amended to clarify that it is subject to clause 124 (inducing another person to request or access voluntary assisted dying).

Clause 137 – Protection for persons acting in accordance with Act

Clause 137 protects a person acting in good faith and without negligence in accordance with the Act from civil or criminal liability for that action. However, there should not be any protection for an action taken that a person believes on reasonable grounds is in accordance with the Act (paragraph 137(1)(b) refers). Ignorance of the law is no excuse and paragraph 137(1)(b) should be removed.

Subclause 137(3) should also be removed. A person's actions should not be exempt from scrutiny for professional ethics or standards, or for findings of unsatisfactory professional conduct or professional misconduct. The highest standards of professional conduct should be expected and encouraged without exception, and particularly in relation to voluntary assisted dying.

Clause 138 – Protection for medical practitioner who refers person or seeks information

Clause 138 is confused and unnecessary. It protects a medical practitioner who:

1. refers a patient under the Act and requests a copy of the patient's medical records or information; and
2. examines a patient referred under the Act and gives a copy of the patient's medical records or information as requested.

Clauses 26, 27, 37 and 38 allow a medical practitioner to refer a patient to another medical practitioner for the purposes of determining whether one or more of the eligibility criteria for access to voluntary assisted dying are satisfied in respect of the patient. A medical practitioner who refers a patient under any of these clauses in good faith and without negligence is already protected by clause 137. The medical practitioner does not require further protection.

Secondly, if a medical practitioner is referring a patient to another health professional, the medical practitioner would surely have the patient's medical records and relevant information and not need to request copies. To the extent that the practitioner does not have these records or information, the practitioner is entitled to obtain them as the doctor of the patient. Medical records and information flow between medical practitioners in the normal course of treating patients. It is unclear why there is a need to protect practitioners providing information in relation to voluntary assisted dying, when protection for practitioners providing information in relation to other medical treatment does not exist.

Clause 138 is confused and should be removed. If it is retained, it should be revised so that its purpose is clear.

Clause 139 – Protection for certain persons who do not administer lifesaving treatment

This clause should be removed. If it was reasonable for a person to believe that another person was dying because of self-administering, or being administered, a prescribed substance, the person will not face prosecution for failing to provide lifesaving treatment and does not need legal protection.

Clause 142 – Functions

This clause should be amended to preclude the Voluntary Assisted Dying Board from referring any issue to a person or body mentioned in paragraph 142(1)(f) that relates to the mere fact that a person exercised their right to refuse to participate in any aspect of the voluntary assisted dying process.

Clause 146 – Assistance

Subclause 146(1) allows the Board to appoint a person with special knowledge or skills to assist the Board with particular matters, with the Minister's approval. The need for the Minister's approval should be removed. As noted below, the Board should act independently and in the public interest, and should be free to make appointments to get the assistance it requires without Ministerial approval and oversight.

Part 10 – Division 10 – Accountability

This Division contains 2 clauses:

1. clause 147, allowing the Minister to give directions to the Board about the performance of its functions; and
2. clause 148, entitling the Minister to have access to all information (other than personal information) and documents in the Board's possession.

This Division should be removed. The Board should act independently and in the public interest. The Minister and the Attorney-General appoint Board members. By ensuring quality appointments, individuals with appropriate knowledge and expertise, there is no need for the Minister to have additional oversight of the Board's operations.

It is unclear why the Minister needs access to all information in the Board's possession. The Minister may request the Board to provide advice, information and reports on matters relating to the operation of the Act (paragraph 142(1)(e) refers), and this mechanism for obtaining information from the Board should be sufficient.

Clause 166 – Section 165 may be declared inapplicable

Clause 164 requires a Board member with a material personal interest in a matter being considered, or for consideration, by the Board to disclose the nature of the interest to the Board. Clause 165 prevents the Board member from voting on the matter or being present while the matter is being considered by the Board.

Clause 166 allows the Board to pass a resolution that clause 165 does not apply (so as to allow the Board member concerned to vote on the matter and be present while the matter is being considered by the Board) if the Board members are satisfied that the interest is so trivial or insignificant as to be unlikely to influence the conduct of the Board member who made the disclosure.

Clause 166 should be removed. A material personal interest cannot be trivial and insignificant. An interest that is trivial and insignificant is not material. Further, allowing Board members to participate in matters in which they have a material personal interest is contrary to good governance.

Clause 168 – Minister may declare ss 165 and 166 inapplicable

Clause 168 allows the Minister to declare that section 165 or 166 does not apply generally or in respect of voting on particular matters. Clause 168 should be removed. The Board should act independently, in the public interest and without political interference.

Clause 175 – Disclosure of information

Clause 175 allows the Board, if asked, to disclose information to a public authority or to a person or body for the purposes of education or research. This clause should be removed. The Board is already empowered to disclose matters to a person or body that is relevant to their functions (paragraph 142(1)(f) refers), and to publicly report on a range of matters (clause 179 refers). In the interests of transparency, any information that was intended to be able to be disclosed under this clause, should be available to the public at large. No one should be able to gain information from the Board that is not otherwise publicly available.

Clause 176 – Board to record and keep statistical information

Subclause 176(2) allows the Minister to give the Board a written direction requiring the Board to record and keep statistical information about a matter relating to voluntary assisted dying and include this information in the annual report. Subclause 176(3) requires the Board to comply with the direction.

Subclauses 176(2) and (3) should be removed. As mentioned above, the Board should operate independently and in the public interest and should not be subject to direction by the anyone, including the Minister.

Part 10 – Division 10 – Miscellaneous

This Division should be amended to include a new provision requiring the Board to publicly report, each quarter, on:

1. the number of persons who have made requests under the Act during the previous quarter; and
2. the number of persons who have died during the previous quarter as a result of self-administering, or being administered, a prescribed substance.

This quarterly reporting requirement should be additional to the Board's obligation to prepare an annual report. Clause 179 should also be amended to require this information to be included in the annual report.

This information should also be required to be available on the Board's website.

Part 11 – Access standard

Clause 180 requires the Health Minister to issue a standard setting out how the Ministry of Health intends to facilitate access to voluntary assisted dying for New South Wales residents, including access to:

1. the services of medical practitioners and other persons who carry out functions under the Act; and
2. prescribed substances; and
3. information about accessing voluntary assisted dying.

This clause is unnecessary and should be removed.

A voluntary assisted dying care navigator service is proposed with a purpose of providing information in relation to voluntary assisted dying, including information about how to access services of medical practitioners and other relevant persons (clause 185 refers).

There is no need to facilitate access to prescribed substances other than in accordance with the process set out in the Act. This process contains safeguards to ensure that prescribed substances are handled and dealt with by a limited number of people; broader access or access under any other terms is both unnecessary and irresponsible.

Clause 182 – Communication between patient and practitioner

Clause 182 allows practitioners to communicate with patients using audio-visual means. It, and any reference in the Bill to audio-visual communication, should be removed. Any request or decision under the Act can be made in person; the law does not preclude medical practitioners from visiting terminally ill patients. The convenience of online communication should not outweigh the potential for abuse that may not be detectable in such communication, such that a person may not be acting voluntarily. Given the gravity of the decision being made, nothing less than face to face communication should suffice.

OR

This clause should be removed. Such communications are precluded by Commonwealth law (acknowledged by subclause (3)), and it is irresponsible to enact a provision that might lead practitioners to believe that online communications are possible.

Clause 184 – Information about voluntary assisted dying

This clause should be removed. If information about voluntary assisted dying can be made available lawfully, there is no need for a legislative provision allowing it.

Clause 188 – Interpreters

Just like registered health practitioners, accredited interpreters should have the right to refuse to participate in any step in the voluntary assisted dying process. See our comments under **Part 4 – Division 1 – new provision** above.

Clause 189 – Relationship with Guardianship Act 1987 and Powers of Attorney Act 2003

This provision is poorly drafted. Clause 189 should provide that voluntary assisted dying is not a matter for which provision may be made under either Act. The Acts would not, in and of themselves, apply to voluntary assisted dying.

Clause 190 – Review of Act

Subclause 190(2) should be removed. Instead, a review should be required to include a review of the eligibility criteria (clause 16 refers).

AMENDMENTS TO OTHER LEGISLATION

Schedule 1A
Births, Deaths and Marriages Registration Act 1995

Amendment [1] creates an artificial distinction between the cause of death and the manner of death. It should be amended as follows:

1. the words "the cause of death as" should be removed from proposed paragraph 42(3)(a); and
2. paragraph (b) should be revised to provide:

   "(b) both:

   (i) the fact that the person requested voluntary assisted dying under the *Voluntary Assisted Dying Act 2021*; and

   (ii) how the person died, whether as a result of self-administering, or being administered, a prescribed substance under that Act.

Amendment [2] should be removed. The issue of a certificate should faithfully replicate the entry in the Register.

Criminal Procedure Act 1986

Amendment [1] provides for the offence of inducing another person to request or access voluntary assisted dying to be tried as a summary offence. Consistently with our comments on clause 124, this amendment should be removed.

Ombudsman Act 1974

Amendments [1] and [2] would preclude a person making a complaint to the Ombudsman about the conduct of the Voluntary Assisted Dying Board.

These amendments should be removed. The Board should act independently and in the public interest. To the extent that it does not do so, it should be subject to the Ombudsman's oversight, in the same way as other public authorities.

Schedule 1 of the Act should also be amended to specifically include:

1. conduct of a registered health practitioner exercising their right to refuse to participate in any aspect of the voluntary assisted dying process under the *Voluntary Assisted Dying Act 2021*; and
2. conduct of a faith-based residential facility, health entity or health care establishment (within the meanings set out in section 88 of the *Voluntary Assisted Dying Act 2021*) exercising their right to refuse to act, actively or passively, to facilitate any step of the voluntary assisted dying process under that Act.

Health Practitioner Regulation National Law (NSW)

This law should be amended to specifically state that the mere fact that a health practitioner exercised their right to refuse to participate in any aspect of the voluntary assisted dying process under the *Voluntary Assisted Dying Act 2021* may not be the subject of a notification or complaint under the national law.

Schedule 1 Dictionary

Definition of *family member*

This definition should be amended to include a child of a sibling of the person's parent or step parent, to reflect the extended nature of families in culturally and linguistically diverse communities and the potential for these persons to influence a person.

Definition of *pressure or duress*

This definition includes terms that themselves should be defined. For example, **abuse** should be defined and take into account the findings of the Royal Commission into Aged Care Quality and Safety and the interim report of the Disability Royal Commission.

The Royal Commission into Aged Care Quality and Safety found that abuse could include physical and sexual abuse, and abuse from inappropriate restrictive practices. The Royal Commission recognised that restrictive practices "which are activities or interventions, either physical or pharmacological, that restrict a person's free movement or ability to make decisions" can result in "serious physical and psychological harm and, in some cases, death" and noted that "substandard care and abuse pervades the Australian aged care system". Given this, the term is too significant to be left undefined in the definition of ***pressure or duress***.

GENERAL SUBMISSION

In addition to our specific submissions on the clauses of the Bill we make the following observations about why introducing any kind of voluntary assisted dying legislation is contrary to the life and dignity of all New South Wales residents.

Residents of New South Wales Deserve Quality Palliative Care

An ageing population requires greater availability of quality palliative care services. However, current palliative care services are not adequate to meet the needs of the elderly and dying in New South Wales.

The ACL acknowledges Mr Dominic Perrottet's undertaking, as Premier of New South Wales, to increase funding with a view to improving the quality and availability of palliative care services in NSW. This recognises that residents of New South Wales deserve the best end-of-life care.

Associate Professor Natasha Michael is an expert in palliative care and is concerned that a misunderstanding of palliative care has created an enthusiasm physician assisted suicide. She writes:

> *"Palliative care is deeply misunderstood. It is viewed simply as the care of the dying, without understanding the totality of what it can offer, when it is done well, Stories of bad deaths arise not simply from the memory of the repugnance of death, but from one of ill preparation and failure of professionals and society to help families delve deeply into what matters most."*[1]

The Australian Medical Association's 2016 position statement on Euthanasia is very clear that the Australian medical community sees palliative care as a top priority in the provision of end-of-life care and that it should be prioritised above access to VAD.[2] The ACL agrees with the AMA's statement that as a matter of highest priority, governments should strive to improve end of life care for all.[3] The AMA has stated that the government should prioritise palliative care through:

1. *the adequate resourcing of palliative care services and advance care planning;*
2. *the development of clear and nationally consistent legislation protecting doctors in providing good end of life care; and*
3. *increased development of, and adequate resourcing of, enhanced palliative care services, supporting general practitioners, other specialists, nursing staff and carers in providing end of life care to patients across Australia*.[4]

Doctors have taken the Hippocratic Oath and should be providing healing medical care to their patients. Doctors should not be co-opted into assisting the vulnerable to commit suicide. The AMA has said that doctors should not be involved in medical interventions that have as their primary intention the ending of a person's life.[5]

Voluntary Assisted Dying is a Danger to the Most Vulnerable

Introducing any kind of state-assisted suicide legislation is an abrogation of our responsibility as a society to some of the most vulnerable members of our community.

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[1] Michael, Natasha, "We can't let voluntary assisted dying negate our commitment to the ill" (The Age, 23 May 2019) <https://www.theage.com.au/national/victoria/we-can-t-let-voluntary-assisted-dying-negate-our-commitment-to-the-ill-20190522-p51q3v.html>, last accessed 15/06/2021.

[2] Australian Medical Association, "Position Statement: Euthanasia and Physician Assisted Suicide" (2016) <https://www.ama.com.au/sites/default/files/documents/AMA_Position_Statement_on_Euthanasia_and_Physician_Assisted_Suicide_2016.pdf>, last accessed 29/06/2021, [1.5].

[3] Ibid, [1.6].

[4] Ibid.

[5] Ibid, [3.1].

Paul Keating understood this when he wrote the following during the public debate about assisted suicide laws in Victoria.

> *"[the Victorian Bill] constitutes an unacceptable departure in our approach to human existence and the irrevocable sanctity that should govern our understanding of what it means to be human… What matters is the core intention of the law. What matters is the ethical threshold being crossed. What matters is that under Victorian law there will be people whose lives we honour and those we believe are better off dead. In both practical and moral terms, it is misleading to think allowing people to terminate their life is without consequence for the entire society. Too much of the Victorian debate has been about the details and conditions under which people can be terminated and too little about the golden principles that would be abandoned by our legislature."*[6]

Even though supporters of VAD maintain that VAD is about ensuring autonomy and control, it is extremely difficult to ensure that someone's decision to access VAD is free and autonomous. Pressure can be applied directly by other individuals.

No number of safeguards will protect the vulnerable against individuals of ill-will who are motivated to get around them. It is also well known that most of the abuse of the elderly comes from within the family. Doctors, even if they are well meaning can be subjected to pressure by family members of the vulnerable and dying. A 2011 survey of 800 family doctors in the Netherlands found that nearly half had felt "pressured by patients or their relatives" to use euthanasia.[7]

Pressure can also be applied indirectly. The fact that VAD would be an option applies some indirect pressure itself, as it will mean that VAD is one available option for someone's end-of-life choices. Palliative care will not be viewed as a necessity but rather a choice. The old person who now has the choice to select VAD may feel pressured over their 'selfish' choice to stay alive and be a burden to their families. Legalising VAD will apply pressure both directly and indirectly on the vulnerable to end their lives, either by choosing to die for the benefit for others or for the lack of better options.

Voluntary Assisted Dying Normalises Suicide

Normalising suicide as a legitimate end-of-life choice in European countries such as Belgium and the Netherlands has seen a dramatic increase in VAD in those countries along with a relaxing of the ease of access.

A 2012 Belgian report from the European Institute of Bioethics noted that after a decade of euthanasia, Belgian society was becoming desensitised to the seriousness of suicide and regarding it

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[6] Keating, Paul, "Voluntary euthanasia is a threshold moment for Australia, and one we should not cross" (The Sydney Morning Herald, 19October 2017) <https://www.smh.com.au/opinion/paul-keating-voluntary-euthanasia-is-a-threshold-moment-for-australia-and-one-we-should-not-cross-20171019-gz412h.html>, last accessed 16/06/2021.

[7] Dutch News.snl, "One third of doctors have refused a euthanasia request" (29 Jul 2011) <https://www.dutchnews.nl/news/2011/07/one_third_of_doctors_have_refu/>, last accessed 29/06/2021.

as a trivial matter.[8] Since legalising euthanasia in 2002, Belgium has steadily opened-up access to a broader range of patients suffering from mental conditions.[9]

This is a far cry from the access that was originally usually only accessed by terminally ill cancer patients. Twelve years after the introduction of euthanasia laws in Belgium, the laws were relaxed to allow access to lethal injection to children of any age.[10] The numbers of deaths in Belgium by Euthanasia have been steadily growing. In the 5-year period between 2008 and 2013 alone the number of deaths increased by 250%.[11]

A similar trajectory has been documented in the Netherlands. Even though the Dutch law requires unbearable pain to be experienced, 20% of Dutch GPS surveyed said that they were willing to euthanise a patient who was merely "tired of life".[12] There have been documented cases of people being euthanised for mental distress and even the suggestion of creating mobile euthanasia units that can travel to euthanise patients whose own doctors refuse to do so.[13]

A society that legalises the state-sanctioned killing of the sick and dying will only find it easier to extend access to suicide to others who are vulnerable and despite their distress and situation, should never be able to take their own lives.

Overseas experience suggests that we cannot be certain that the proposed legislation will not be expanded to cover situations not originally envisaged. New South Wales does not need to take this risk. The current state of affairs obviates the need for the *Voluntary Assisted Dying Bill 2021*.

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[8] European Institute of Bioethics, "Euthanasia in Belgium: 10 years on" (April 2012) < https://www.ieb-eib.org/docs/pdf/2012-10/doc-1554801153-41.pdf >, last accessed 29/06/2021, 7.

[9] Rachel Aviv, "The Death Treatment: When should people with a non-terminal illness be helped to die?" (The New Yorker, 15 June 2015) <https://www.newyorker.com/magazine/2015/06/22/the-death-treatment>, last accessed 29/06/2021.

[10] Robert-Jan Bartunek, "Belgium Allows euthanasia for terminally ill children" (Sydney Morning Herald, 14 February 2014) <https://www.smh.com.au/world/belgium-allows-euthanasia-for-terminally-ill-children-20140214-hvcb9.html> last accessed 29/06/2021.

[11] Commission Fédérale de Contrôle et D'évaluation, "De L'euthanasie Sixieme Rapport Aus Chambres Législatives" (Années 2012–2013) <https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/federale_controle_en_evaluatiecommissie_euthanasie-fr/19097638_fr.pdf>, last accessed 29/06/2021.

[12] Above no.8.

[13] Kate Connolly, "Dutch mobile euthanasia units to make house calls" (The Guardian, 1 March 2012) <https://www.theguardian.com/world/2012/mar/01/dutch-mobile-euthanasia-units>, last accessed 29/06/2021.

CONCLUSION

The Voluntary Assisted Dying Bill 2021 must be rejected. It contains too many flaws, placing the care of the vulnerable and the conscience of health care workers in jeopardy.

The ACL strongly opposes the Bill and welcomes any opportunity to speak further on this very important issue.

Wendy Francis
National Director / Politics