Submission No 50

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Organisation: HOPE: Preventing Euthanasia and Assisted Suicide Ltd

Date Received: 22 November 2021

HOPE
Preventing Euthanasia & Assisted Suicide

22 November 2021

Director
Standing Committee on Law and Justice
Parliament of New South Wales
Macquarie Street
SYDNEY NSW 2000

Dear Director,

HOPE is pleased to present a submission to the Standing Committee on Law and Justice Inquiry into the Provisions of the *Voluntary Assisted Dying Bill 2021*.

HOPE: Preventing Euthanasia and Assisted Suicide Ltd is a coalition of groups and individuals who oppose the legalisation of euthanasia and assisted suicide. We believe that euthanasia and assisted suicide are contrary to human rights and the obligations of a state to its most vulnerable.

The Committee may wish to visit the HOPE: No Euthanasia website which contains many more resources about the issue of euthanasia and assisted suicide: http://www.noeuthanasia.org.au/

We trust this submission will assist the Committee with its deliberations to ensure that the most vulnerable in our community will not be put at further risk of marginalisation, and instead receive the priority care that is characteristic of strong governments and compassionate communities.

We would be pleased to speak with the Committee in relation to any aspect of this Submission.

Yours sincerely,

Branka van der Linden

Director

www.noeuthanasia.org.au

HOPE

Preventing Euthanasia & Assisted Suicide

SUBMISSION TO THE STANDING COMMITTEE ON LAW AND JUSTICE INQUIRY INTO THE PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

21 November 2021

Introduction

It is our considered position that the *Voluntary Assisted Dying Bill 2021* (“the Bill”) should be rejected by the New South Wales Parliament. Legislating to allow deliberate killing is inherently unsafe and the drafting of this particular Bill does nothing to mitigate, and quite a lot to exacerbate, the risks that vulnerable people could be killed wrongfully.

In addition, claims have been made by proponents of the Bill which are not borne out, either upon examination of the specific clauses of the Bill itself, or when the experience in other jurisdictions where euthanasia and assisted suicide has been legalised is examined. We will consider each of these in turn.

In this submission, we refer to the term ‘euthanasia’ to describe the practice of a physician or other health professional ending the life of a patient at the patient’s voluntary request, and ‘assisted suicide’ to describe the practice of a physician or other health professional prescribing a lethal substance to a patient at their voluntary request, in order that the patient may end their own life. These terms represent accurate terminology to describe what is being proposed by the Bill. The phrase ‘voluntary assisted dying’ is used by proponents to refer to both practices but is a recently constructed euphemism which masks and obfuscates the reality of what is being proposed by the Bill.

The legal change to the criminal law being proposed by this Bill is profound and gravely serious. It removes the prohibition against homicide for some citizens in society (namely physicians and other health professionals) by overturning the long-held prohibition in the criminal law and the medical profession against physicians killing their patients or assisting them to suicide. In the words of one commentator, this Bill ‘authorises private citizens to kill other citizens with almost no judicial oversight.’[1] The Parliament should not pass such a law unless it can satisfy itself that allowing euthanasia and assisted suicide in some cases will not lead to the death of individuals who would not otherwise have chosen to be killed. The onus lies on those proposing this radical change to the criminal law to demonstrate that such deaths will not occur; thus far, they have been unwilling or unable to do so.

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[1] https://mercatornet.com/euthanasia-think-hard-theres-no-going-back/75829/

In addition, the very fact of the availability of assisted suicide changes the way everyone dies. As has been stated by Baroness O'Neill, a member of the House of Lords during debates in the United Kingdom on this issue: "Legalising 'assisted dying' places a huge burden on the vulnerable, let alone the vulnerable and depressed … Laws are written for all of us in all situations – not just for the unusually independent."

> *"Legalising 'assisted dying' amounts to adopting a principle of indifference towards a special and acute form of vulnerability; in order to allow a few independent folk to get others to kill them on demand, we are to be indifferent to the fact that many less independent people would come under pressure to request the same."*[2]

Proponents of the Bill claim that it is restricted to only those with terminal illnesses who are suffering unbearable pain, and that only a small number of people will make use of the laws. However, once you allow the law to be changed for one group of people in society, as a matter of logic, it becomes discriminatory to not allow others in society to also avail themselves of the perceived benefits of the law. If the rationale for this change in the law is patient autonomy and a duty to relieve suffering (which underpins the arguments of proponents of the Bill), why should it only be available for those with terminal illnesses and not others who are also suffering, such as people with chronic illnesses or disabilities? In jurisdictions which have legislated to remove the prohibition on doctors their killing patients, we can see how quickly the argument becomes one of equal access and 'discrimination'; whole categories of society are now 'denied' access to something which has come to be characterised as a 'right', and inevitably the law expands. The experience in Canada illustrates how quickly this restriction can be expanded. Its euthanasia and assisted suicide laws came into operation in 2016, and initially allowed terminally ill patients whose death was reasonably foreseeable to access their regime. This has now been expanded in 2021 to allow those with chronic illnesses but who do not have a terminal illness to also access the scheme.

Despite claims that the Bill is 'conservative' and contains strong safeguards, an examination of the clauses contained in the Bill indicates otherwise; a comparison of the Bill with the one that was rejected by the NSW parliament in 2017 demonstrates that there are many provisions that leave open wide the possibility for abuse of the terms.

Concerns regarding specific provisions of the *Voluntary Assisted Dying Bill 2021*

Our position is that this Bill is fundamentally flawed and should be rejected by the Parliament. We have identified some areas in particular that demonstrate the inherent danger the Bill poses, especially to those in our communities who are vulnerable and will be put at risk by such a change in the law.

The Bill allows physicians to suggest euthanasia and assisted suicide to their patients

Unlike the Victorian regime, the Greenwich Bill allows doctors to suggest euthanasia and assisted suicide to their patients. Allowing doctors to suggest death as a 'treatment' option ignores the

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[2] Accessed at https://publications.parliament.uk/pa/ld200506/ldhansrd/vo060512/text/60512-24.htm

enormous influence a doctor has over a patient’s end-of-life decisions. Allowing them to suggest to a patient that they end their life puts vulnerable patients at risk of undue influence from doctors. Sections 10(2) and 10(3) should be deleted.

There is no mechanism in the Bill to prevent coercion

Despite a statement of principles which includes a need to protect persons who may be subject to pressure or duress (4(1)(j)), the Bill provides no mechanism for either the coordinating practitioner or the consulting practitioner to ensure this occurs. The Bill provides that either practitioner must make a decision that the person has decision making capacity, is acting voluntarily, and is not acting as a result of pressure or duress. If either practitioner is unable to make such a decision, they are required to refer the matter to a psychiatrist. However, in the absence of uncertainty on the part of either practitioner, the practitioner is not required to make any positive inquiries into the matter. The Bill does not require them to consult with the patient’s general practitioner, or the patient themselves. The Bill defines ‘pressure and duress’ to include abuse, coercion, intimidation, threats and undue influence. There is no requirement for either physician to specify on what basis such an assessment has been made, i.e. they do not need to provide any information to specify what inquiries led them to reach their decision that the patient meets the eligibility criteria and is not being coerced or acting as a result of pressure or duress.

The decision about whether someone is acting as a result of pressure or duress involves detecting coercion, which is not a medical judgment. Detecting whether a request has been made voluntarily is a matter of factual inquiry by someone with the appropriate skills and training. This is not a skill that physicians are ordinarily qualified or trained to do.

The reality is that undue influence can easily be missed and may be difficult to identify. We know this is the case even for lawyers who are trained to detect it. Where undue influence is established, the law provides a remedy; the contract can be cancelled, and the parties restored to the position they were in before entering into the contract. However, in the case of assisted suicide, a failure to identify undue influence before writing a prescription for a lethal dose will be incapable of remedy once the lethal dose is ingested. There is no way to restore the parties back to the position they were in before the person’s death.

Coercion to end one’s life may be covert or even unintended, such as when elderly patients selflessly choose suicide to relieve their loved ones of the burden of caring for them in their final days. Despite the fact that caring family members might be best placed to detect improper influences on their loved one’s decision, the Bill does not require consultation with the patient’s family. On the other hand, it cannot be assumed that pressure to apply for euthanasia and assisted suicide does not come from family members. Elder abuse by family members is a well-recognised risk factor for the elderly

A doctor who sees the patient in consulting rooms in consideration of medical issues, or a pharmacist who visits to advise on the procedure for swallowing poisons, cannot be expected to detect such covert influences. Given the Bill provides that doctors do not need to meet or physically examine the patient, this risk is further heightened.

Doctors do not need to meet or physically examine the patient

The risk of non-specialist doctors being able to suggest euthanasia and assisted suicide is further exacerbated in light of there being no requirement for coordinating or consulting medical practitioners to physically examine the patient. All medical consultations, including the first and final requests for euthanasia or assisted suicide and the administration decision can all be conducted via telehealth.

Arguably, and as outlined above, this would make detecting coercion impossible.

Sections 19(2)(c) and 48(2)(b) and 182 should be deleted.

Doctors do not need to specialise in a patient's illness

The risks created by allowing doctors to suggest euthanasia and assisted suicide to their patients are then compounded by the terms of the Greenwich Bill, which does not require either the coordinating or consulting practitioner to have specialist expertise in the patient's illness. It is clearly unreasonable to expect doctors without specialist knowledge of the relevant condition to provide the patient with complete information about potential treatments. It is also unreasonable to expect non-specialists to accurately certify that the illness is terminal, and that death is likely to occur within six months (or in the case of neurodegenerative diseases, twelve months).

Section 26(2) should be amended to require the involvement of at least one medical practitioner who is a specialist in the person's illness or disease or medical condition.

Treatable mental illness is no barrier to accessing lethal drugs

The Greenwich Bill makes it clear that mental illness does not make a person ineligible to access euthanasia or assisted suicide. This means that treatable mental health conditions, such as depression, which are common contributors to a suicide decision, do not prevent lethal drugs being prescribed or administered. Further, there is no requirement that a doctor refer a patient suffering a treatable mental illness for psychiatric or psychological assessment or treatment before prescribing them lethal drugs. As the minority report on Victoria's Inquiry into *End-of-Life Choices* pointed out:

> "Depression raises the question about how the depression interacts with decision making. What safeguards need to be in place to protect people from making decisions that might be affected in the short term by a depressive mood that might be manageable or treatable with additional support? Great care needs to be taken where a person is suffering from depression and is seeking either euthanasia or assisted dying."[3]

Despite the complex interplay between depression and other forms of mental illness, the Greenwich Bill does not recognise the existence of mental illness as a disqualifying factor for euthanasia and assisted suicide. Instead, it applies the test of whether a psychological or psychiatric condition affects the patient's decision-making capacity. This question is far harder to answer with certainty and the scope for fatal error is therefore much greater. Only 6 per cent of psychiatrists in Oregon reported being very confident that they could adequately determine whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide in a single evaluation.[4] Another study

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[3] Parliament of Victoria, Legislative Council, Legal and Social Issues Committee, *Inquiry into end of life choices*, Final Report, June 2016, Minority Report, beginning at p.343, Chapter 3.

[4] Ganzini L. et al., "Attitudes of Oregon psychiatrists towards physician-assisted suicide", American Journal of Psychiatry 1996: 153:1469-75. Retrieved: http://ajp.psychiatryonline.org/doi/abs/10.1176/ajp.153.11.1469

found that “physicians are not reliably able to diagnose depression, let alone to determine whether depression is impairing judgment.”[5]

Were Greenwich’s Bill to be passed, patients suffering from potentially treatable mental health conditions, are denied the protection of legislative safeguards that should, at a minimum, require these conditions to be addressed before any request for euthanasia or assisted suicide is contemplated.

No jurisdiction that has legalised assisted suicide and/or euthanasia has managed to devise a robust legislative solution to the problem of distinguishing inerrantly between, on the one hand, depressed people who should be allowed to assisted suicide or euthanasia (on the grounds that their depression is unrelated to their illness and does not affect their decision making capabilities) and, on the other, depressed people those who should not be allowed to access assisted suicide or euthanasia (on the grounds that their mental state is implicated in their suicide decision).

Standard process can be as short as 5 days

The time between a patient’s first and final request for death can be as short as 5 days. This condensed time frame means that there is no time for serious reflection, for family to be notified, or for palliative care or mental health specialists to have time to step in and consult. In some circumstances (where the patient is expected to die or lose mental capacity within 5 days), the time period can be even shorter.

Conscience rights of doctors are not protected

The Greenwich Bill would require doctors who hold a conscientious objection to euthanasia and assisted suicide to nevertheless provide information on these matter to their patients. It also requires a doctor to inform the Voluntary Assisted Dying Review Board every time they conscientiously object to providing euthanasia or assisted suicide. The requirement on doctors to announce their conscientious objection not once, but every time they decline to provide euthanasia or assisted suicide, subjects them to unnecessary and unjust scrutiny.

Conscience rights of institutions are not protected

The Greenwich Bill would not allow aged care facilities to opt out of euthanasia and assisted suicide. Even if staff members do not want to be involved and even if residents are aware of this, every aged care facility is nonetheless required to allow doctors and nurses on to the premises for every stage of the euthanasia and assisted suicide process, including allowing them to enter and kill a patient on site.

Hospitals can object to having euthanasia occur on the premises but must still allow Voluntary Assisted Dying Navigators to consult with patients on site.

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[5] Murphy G.E. George E. Murphy, The Physician’s Responsibility for Suicide. II. Errors of Omission, 82 Annals Internal Med. 305 (1975), cited in Herbert Hendin and Kathleen Foley, “Physician-Assisted Suicide in Oregon: A Medical Perspective” 106 *Mich. L. Rev.* 1613 (2008), at p.1623.

Offenders protected against prosecution

The Greenwich Bill includes a 2-year statute of limitations, which means that once evidence comes to light of an alleged offence, prosecutors only have two years to bring charges. If they don't, then a person can go unpunished for a wrongful euthanasia death. This distinguishes it from other homicide laws, which have no statute of limitations. It is hard to understand what purpose such a statute of limitations serves other than to make the prosecution of murder, disguised as euthanasia or assisted suicide, more difficult.

Process shrouded in secrecy

Those involved in the euthanasia or assisted suicide process, either because of their role as a medical professional or as a party to Tribunal proceedings reviewing decisions made under the law, face up to 12 months in prison if they disclose personal information about a patient or any of their medical practitioners. Even the Health Minister is not allowed to access personal information.

The rationale presented for this claims the measure is necessary to protect a patient's privacy. However, shrouding the process in such impenetrable secrecy will predictably frustrate the robust monitoring which is necessary to detect malfeasance. Where euthanasia and assisted dying processes provide the means to hide nefarious killings, it would be unreasonable to suppose that this potential will not be exploited. The law appears to take no account of the fact that the extreme privacy it secures for those patients who freely choose to die will have the unintended consequence of emboldening criminals to action by providing the means to obscure murder.

Very little detail recorded by the Voluntary Assisted Dying Board

The only statistical information required to be kept by the Voluntary Assisted Dying Board is the relevant disease or illness, the age of the patient, and whether they live in regional NSW. In Oregon – often lauded as the gold standard of assisted suicide regimes – the government collects and reports information about whether a patient had been given a psychological assessment before they were given lethal drugs, whether they had private health insurance, their annual income, their education level and their reasons for requesting assisted suicide. Additional information about the doctors, such as the length of time the doctor had been treating the patient, is also collected, and made public. By contrast, the provisions of the Greenwich Bill will create significant lacunae in the information collected and reported - lacunae that will, again, frustrate proper monitoring and scrutiny and therefore, inevitably, reduce public confidence that these procedures are not being misused.

Death certificates are falsified

Section 12 should be removed altogether. It seeks to perpetuate a legal fiction that the person does not die by suicide, but rather as a result of their illness or disease.

In addition, new section 43(3)(a) of the *Births, Deaths and Marriages Registration Act 1995 No 62 (NSW)* should be deleted. This section requires that a person's illness, disease or condition be listed as the cause of death rather than as a result of the administration of a 'voluntary assisted dying substance'. Proponents of this Bill argue that a change in the law to allow euthanasia and assisted suicide is necessary to allow people to 'die with dignity'. How accurate records of the cause of death would interfere with this objective is unclear. On the other hand, the problems created by these polite fictions with regard to the rigorous scrutiny necessary to prevent their misuse have been canvassed above. A nebulous idea of “dignity” should not be purchased for some at the cost of increased risk to others.

Safeguards that were in the 2107 Khan Bill that are not in the 2021 Greenwich Bill

In 2017, the NSW Legislative Council voted against the *Voluntary Assisted Dying Bill 2017*, tabled by Trevor Khan MLC (the **Khan Bill**). The Khan Bill, rejected by NSW MLCs, had many protections that have been dispensed with in the *Voluntary Assisted Dying Bill 2021* (the **Greenwich Bill**.)

The following section identifies ten important safeguards that were present in the Khan Bill but are not present in the Greenwich Bill, currently before the NSW Parliament.

Age limit reduced

The Khan Bill included a safeguard that required a person to be 25 years of age or older to be eligible for euthanasia or assisted suicide. The Greenwich Bill reduces this to 18 years of age.

Specialist safeguard removed

The Khan Bill included a safeguard that required at least one of the doctors signing off on a patient’s request for euthanasia or assisted suicide to be a specialist in the terminal illness suffered by the patient. The Greenwich Bill does not require either doctor signing off on the patient’s death to be a specialist in the patient’s illness.

Despite not being a specialist in the patient’s illness, the doctor is still empowered to provide information about a patient’s diagnosis and prognosis, treatment options, the likely outcomes of that treatment, palliative care options and the likely outcomes of palliative care. The Greenwich Bill’s presumption of medical omniscience and infallibility for all doctors is clearly unrealistic. Planning for a best-case scenario, the Bill fails to anticipate the less-than-optimal circumstances to which the law will apply or to mitigate the risk that a patient might be influenced to kill themselves on the basis of incorrect or incomplete information.

Physical examination safeguard removed

The Khan Bill included a safeguard that required both doctors signing off on a patient’s eligibility to examine their patient in-person and sign the written declaration requesting access to euthanasia or assisted suicide in the doctors’ presence. The Greenwich Bill allows for the first and final consultations, as well as the administration decision, to be made using audio-visual communication and for the relevant written declarations to be signed electronically and delivered to the doctor.

Independence safeguard removed

The Khan Bill included a safeguard that required the two doctors signing off on a patient’s eligibility for euthanasia or assisted suicide to be independent of each other, in order to remove the risk of any undue influence. The Greenwich Bill has removed this requirement of independence.

Mental health check safeguard removed

The Khan Bill included a safeguard that required a patient to be examined by a qualified psychologist or psychiatrist after they made a request for euthanasia or assisted suicide. The Greenwich Bill removed the mandatory examination by a mental health expert and left this instead to the discretion of the doctor.

Palliative care referral safeguard removed

The Khan Bill included a safeguard that required a patient be offered a referral to a palliative care specialist. The patient could accept or refuse that referral. The Greenwich Bill removes the requirement that the choice of palliative care be offered to a patient.

Filming of a non-written request safeguard removed

The Khan Bill included a safeguard that a video recording be made of a request for euthanasia or assisted suicide that was made by a patient who was physically incapable of signing a written request or who required an interpreter to do so. This was a protection against a doctor or an interpreter deliberately, negligently or recklessly misreading a patient's end-of-life decision. The Greenwich Bill removes this safeguard and even allows a patient to request death by way of non-specified 'gestures' that are not recorded.

Coronial reporting safeguard removed

The Khan Bill included a safeguard that made every euthanasia and assisted suicide death reportable to the NSW Coroner. The Greenwich Bill has removed the mandatory coronial oversight of euthanasia and assisted suicide deaths.

Medical membership on Voluntary Assisted Dying Review Board removed

The Khan Bill required that the Voluntary Assisted Dying Review Board included the State Coroner or their nominee, representatives from the Medical Board of Australia, the Australian Medical Association or the Royal Australasian College of Physicians, the Royal Australian and New Zealand College of Psychiatrists or the Australian Clinical Psychology Association Limited, Palliative Care NSW and others.

The Greenwich Bill does not require the presence of any medical practitioner or any medical group on the Voluntary Assisted Dying Review Board. The Greenwich Bill only requires an experienced lawyer to be part of the Board.

Consequences for non-compliance watered down

The Khan Bill only provided protections from prosecutions for those who acted lawfully under the bill. The Greenwich Bill provides legal protections for those who believe they are acting lawfully, irrespective of whether or not they do, in fact, comply with the law.

Will legalising euthanasia and assisted suicide reduce suicide deaths?

A further matter that is relevant to the Bill is the claim that this legislation is needed to prevent the unnecessary and cruel suicides that are currently being completed by people who have a terminal illness but do not have access to euthanasia and assisted suicide.

In his second reading speech for the *Voluntary Assisted Dying Bill 2021*, Independent MP Alex Greenwich asserted that "at least 20 percent of suicides in people over 40 are associated with a terminal illness." Mr Greenwich obtained this data from a report commissioned by the pro-euthanasia lobby group, Dying with Dignity. In turn, Dying with Dignity cited a report from the National Coronial Information System, entitled: *Intentional self-harm deaths of people with terminal or debilitating physical conditions – New South Wales 2019* (Report).[6] Quoting statistics that appear to support their argument, both Dying with Dignity, and therefore Mr Greenwich, have failed to present the whole picture.

Certainly, the report stated:

> *There were 495 deaths of relevance identified that were reported to a New South Wales coroner where the deceased died as a result of an act of intentional self-harm.*
>
> *In 101 of these cases (20.4%), the deceased had a terminal or debilitating physical condition, or had experienced a significant decline in physical health prior to their death.*

It is from this summary of the data that Mr Greenwich made his claim.

However, the 495 deaths were not the total number of suicide deaths in NSW in 2019. According to the Australian Institute of Health and Welfare[7], there were 943 suicide deaths in 2019 in that year.

The 101 suicides in which "the deceased had a terminal or debilitating physical condition or had experienced a significant decline in physical health prior to their death", reported by the National Coronial Information System, therefore represents 10.7%, not 20.4% of all suicide deaths.

Further, these 101 deaths included suicides by an unknown number of individuals who suffered non-terminal conditions and who would therefore be ineligible for euthanasia or assisted suicide even were the Greenwich Bill passed. The National Coronial Information System tells us only that these 101 suicides were associated with "reduced mobility, an inability to work, or a requirement for care arrangements such as nursing home admission, or the deceased was described as experiencing pain and suffering." The Report further clarifies that:

> *"[Data] contained in this report does not necessarily infer a correlation between a terminal or debilitating physical condition and the deceased's intention to engage in self-harm, nor does*

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[6] National Coronial Information System. *Intentional self-harm deaths of people with terminal or debilitating physical conditions – New South Wales 2019.* July 2019. Victoria, Australia.

[7] Australian Institute of Health and Welfare. Data from Suicide Registers. 30 September 2021. Available at: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/suspected-deaths-by-suicide/data-from-suicide-registers

> *it indicate that the condition was the sole or primary contributing factor to the deceased's intention to engage in self-harm. Caution is advised when interpreting this data."*

Dying with Dignity, and therefore Mr Greenwich, has misrepresented correlation as though this were proof of causation when there is no justification for reaching this conclusion.

Similar figures invoked in support of assisted suicide laws in other states were also demonstrated to be misleading for various reasons. For example, in the coronial cases examined in Victoria, only 13% of those who committed suicide had access to palliative care.[8] In Tasmania, oncologists Professor Ray Lowenthal AO and Associate Professor Marion Harris said the coronial data had been misrepresented, noting that many of those who died by suicide had "undiagnosed and untreated depression" and would not have qualified for assisted suicide or euthanasia.[9]

Suicide deaths are an opportunity to advocate better access to physical and mental health care. It is disingenuous to infer that euthanasia and assisted suicide would materially reduce suicide figures.

Access to health in regional, rural and remote New South Wales

This Bill must be considered by the Parliament in the context of the inquiry currently examining health outcomes in rural and regional NSW. Since September 2020, a Health Portfolio Committee (the Committee) has been conducting an inquiry into Health outcomes and access to health and hospital services in rural, regional and remote parts of New South Wales. Hearings are scheduled to finish by the end of the year, and the Committee is not expected to report until 2022.

Several preliminary findings, however, are highly relevant to the current debate on the *Voluntary Assisted Dying Bill 2021,* including:

- **Lower life expectancy in regional and rural NSW**

  Regional and rural communities in NSW have a lower life expectancy than those in urban areas, with the greatest gap in life expectancy experienced by Indigenous communities. Later diagnosis and limited treatment options impact the survival rates of patients.[10]

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[8] J. Dwyer, R. Hiscock, C. O'Callaghan et al. Characteristics of patients with cancer who die by suicide: Coronial case series in an Australian state. *Psychooncology.* 28 (11) (2019), pp. 2195-2200

[9] Lowenthal R. Harris M. Why Tasmania should reject its fourth VAD bill. The Mercury. 2 December 2020. Available at: https://www.themercury.com.au/news/opinion/talking-point-why-tasmania-should-reject-its-fourth-vad-bill/news-story/a92044fcfd57a8b9c3817529b38a8a2b

[10] Australian Medical Association (NSW) Ltd. Submission into the Inquiry into Health outcomes and access to health and hospital services in rural, regional and remote New South Wales. 19 January 2021. Available from: https://www.parliament.nsw.gov.au/lcdocs/submissions/70253/0573%20Australian%20Medical%20Association%20(NSW)%20Ltd.pdf

- **Disease and suicide increase with remoteness**

  The Committee heard that the burden of disease from cancers and diseases of the cardiovascular, respiratory and endocrine systems increase with remoteness. The risk of suicide also increases in remote areas.[11]

- **Limited access to specialists**

  The Committee received evidence that asbestosis patients in rural areas have waiting periods of more than 12 months to see a specialist, even if they are willing to travel to a regional centre in order to be able to receive care.[12]

- **Complete cancer services lacking**

  Regional centres do not provide access to "complete cancer services" meaning that patients have to choose between travelling to metropolitan centres (and away from family and other support networks) to access allied and mental health services or choosing to stay close to home and accepting inferior chances of survival.[13] The Committee heard of cancer patients who did not have the financial resources to travel to the city for treatment having to settle for compromised treatment locally instead.

- **Lack of staff means some health services unavailable**

  Even hospitals that might technically offer certain medical services do not necessarily have the staff to deliver them. For example, a new hospital at Tumut does not have a resident anaesthetist, nor a resident GP surgeon. This means that there is no emergency surgery possible in the hospital, a situation described by Dr Geoffrey Pritchard in testimony before the Committee as 'Third World practice.'[14]

- **Promised funding rejected**

  The Committee heard that funding for local radiation oncology services specifically designated for the Eurobodalla region in pre-election promises from all major federal parties has been

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[11] Portfolio Committee No. 2 – Health. Health outcomes and access to health and hospital services in rural, regional and remote New South Wales. Transcript of hearing on Friday 19 March 2021. Available from: https://www.parliament.nsw.gov.au/lcdocs/transcripts/2514/Transcript%20-%20RRR%20health%20outcomes%20-%2019%20March%202021%20-%20CORRECTED.pdf

[12] Murrumbidgee Council. Submission into the Inquiry into Health outcomes and access to health and hospital services in rural, regional and remote New South Wales. 14 January 2021. Available from: https://www.parliament.nsw.gov.au/lcdocs/submissions/70138/0470%20Murrumbidgee%20Council.pdf

[13] Australian Medical Association (NSW) Ltd. Submission into the Inquiry into Health outcomes and access to health and hospital services in rural, regional and remote New South Wales. 19 January 2021. Available from: https://www.parliament.nsw.gov.au/lcdocs/submissions/70253/0573%20Australian%20Medical%20Association%20(NSW)%20Ltd.pdf

[14] Portfolio Committee No. 2 – Health. Health outcomes and access to health and hospital services in rural, regional and remote New South Wales. Transcript of virtual hearing via videoconference on Wednesday 6 October 2021. Available from: https://www.parliament.nsw.gov.au/lcdocs/transcripts/2586/Transcript%20-%20RRR%20Health%20inquiry%20-%206%20October%202021%20-%20UNCORRECTED.pdf

rejected. One resident of the region told the Committee she had to travel to either Canberra or Sydney to receive radiation treatment instead.[15]

- **Palliative care "completely inadequate"**

  The Committee heard that the overwhelming response from members of the Australian Medical Association (NSW) was that palliative care was inadequate. One member commented that there is an infrequent fly in, fly out doctor and two community nurses for tens of thousands of people living in the community. Another reported a single palliative care doctor for approximately 100,000 people.[16] Even in Orange, a regional centre, there are only two dedicated palliative care beds.[17]

- **Impact of lack of General Practitioners**

  The Committee heard of the impact that a lack of General Practitioners has on the access to health care in regional communities. GP referrals are required to access specialist and most allied health services, as well as the NDIS scheme. The lack of GPs available presents an additional barrier to specialist and allied health care.[18]

- **COVID exacerbated the lack of healthcare access**

  Philip Stone, General Manager of the Edward River Council, told the Committee that COVID was a particular challenge for the 1500 local patients who would usually travel to Victoria for oncology, immunology and other services. Ruth McRae, the Mayor of Edward River Council, said that they needed to fight hard to get people who would usually access cross-border health services to still have access to the higher level of care despite border closures.

- **Set the Standard**

  The disparity in access to essential care between regional and metropolitan areas has prompted the Leukaemia Foundation to launch a campaign titled 'Set the Standard.' The campaign highlights that more than 1300 Australians die unnecessarily each year from blood cancers such as leukaemia and lymphoma because they live in resource-starved regional towns. "Leukaemia Foundation launched its "Set the Standard" campaign, with the aim of

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[15] Ibid.

[16] Australian Medical Association (NSW) Ltd. Submission into the Inquiry into Health outcomes and access to health and hospital services in rural, regional and remote New South Wales. 19 January 2021. Available from: https://www.parliament.nsw.gov.au/lcdocs/submissions/70253/0573%20Australian%20Medical%20Association%20(NSW)%20Ltd.pdf

[17] Orange Push for Palliative. Submission into the Inquiry into Health outcomes and access to health and hospital services in rural, regional and remote New South Wales. 14 January 2021. Available from: https://www.parliament.nsw.gov.au/lcdocs/submissions/70139/0471%20Orange%20Push%20for%20Palliative%20(OP4P).pdf

[18] Portfolio Committee No. 2 – Health. Health outcomes and access to health and hospital services in rural, regional and remote New South Wales. Transcript of hearing on Wednesday 16 June 2021. Available from: https://www.parliament.nsw.gov.au/lcdocs/transcripts/2558/Transcript%20-%2016%20June%202021%20-%20Gunnedah%20-%20UNCORRECTED.pdf

getting governments to commit to standardised care and treatment, regardless of where a person lives. The Set the Standard website[19] reads:

> *Getting the best blood cancer treatment can be challenging. Difficulties can arise depending on where a person lives and, in some cases, whether they can afford to pay for tests and treatments. It's not fair that your postcode or other personal circumstances could affect whether you get the best blood cancer treatment.*

Lessons about euthanasia and assisted suicide from overseas jurisdictions

The experience from jurisdictions that have legalised euthanasia and assisted suicide is relevant to any consideration of whether the NSW Parliament should legalise the practice in NSW.

The World Medical Association is strongly opposed to euthanasia

The World Medical Association (**WMA**), and more than 95 percent of its constituent national medical associations oppose euthanasia and assisted suicide. The WMA states that it is "firmly opposed to euthanasia and physician-assisted suicide."[20]

Euthanasia and assisted suicide are still rejected by most of the world

Only ten countries, and a handful of US and Australian states, have legalised some form of euthanasia or assisted suicide. The overwhelming majority of countries still reject the legalisation of doctors administering or prescribing lethal drugs to their patients.

The categories of eligibility expand

In countries where euthanasia or assisted suicide has been legalised, the categories of people eligible for euthanasia expand so that more people are able to access lethal drugs. In the Netherlands, one of the first countries to legalise euthanasia, it is now available to children, newborn babies with serious disabilities, and people with dementia and mental illness, such as depression, without physical illness.

When Canada legalised euthanasia five years ago, it was only available for those with a terminal illness. It has since been extended to those with a disability, even if the condition is not fatal. In 2023, the eligibility for euthanasia will also be extended to those who only have a mental illness.

The number of people accessing euthanasia increases

In countries that report euthanasia and assisted suicide deaths, the rate of people accessing lethal drugs increases over time. For example, euthanasia accounted for 1.9 percent of deaths in the Netherlands in 1990 to 4.4 percent of deaths in 2017.[21] In the first ten years of legalised assisted

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[19] https://setthestandard.org.au/

[20] World Medical Association. WMA Declaration on Euthanasia and Physician-Assisted Suicide. October 2019. Available from: https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/

[21] Groenewoud AS, Atsma F, Arvin M, et al *Euthanasia in the Netherlands: a claims data cross-sectional study of geographical variation* BMJ Supportive & Palliative Care Published Online First: 14 January 2021. doi: 10.1136/bmjspcare-2020-002573

suicide in Oregon, an average of 34 people died each year from lethal drugs. In the most recent ten years, the average number of deaths has risen to 136 deaths per year. In Canada, numbers of euthanasia deaths are increasing most dramatically. In 2016, the first year the laws came into effect, 1018 Canadians were euthanised. In 2020, the fifth year of the law's operation, this number had grown to 7595 people.[22]

There is a suicide contagion effect

The legalisation of assisted suicide has a contagion effect, increasing the rate of suicide in the community. The suicide rate in Oregon, where assisted suicide was legalised in 1997, has been increasing. In 2012, Oregon's suicide rate was 42% higher than the national average.[23] This does not include deaths by assisted suicide, as they are recorded as being deaths due to the underlying condition.

Euthanasia and assisted suicide as a 'specialisation'

In jurisdictions where euthanasia and assisted suicide have been legal for a long time, it is apparent from the length of the doctor-patient relationship that those doctors assessing eligibility for death are not the treating doctors of patients. Instead, there is the emergence of doctors specialising in prescribing lethal drugs.

For example, the 2020 statistics from Oregon show the median length of the relationship between the patient and the doctor who prescribed the lethal drugs was 8 weeks, and the median length of time between the first request for assisted suicide and patient death was 32 days.[24] This means that the median time between the first encounter between a drug-prescribing doctor and a request for death is less than four weeks.

Pain is rarely a motivating factor for euthanasia or assisted suicide requests

Oregon keeps detailed statistics on those patients who request assisted suicide. Since the legalisation of assisted suicide in Oregon 24 years ago, the top five reasons given by those who request (and are given) assisted suicide drugs have been:

- Losing autonomy
- Less ability to engage in activities making life enjoyable

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[22] Government of Canada. Second Annual Report on Medical Assistance in Dying in Canada 2020. 30 June 2021. Available from: https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2020.html

[23] Oregon Health Authority. Oregon Vital Statistics Annual Report 2015. Volume 2: Mortality; Fetal and infant mortality. Available from: https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/VITALSTATISTICS/ANNUALREPORTS/VOLUME2/Documents/2015/2015VOL2FINAL.pdf

[24] Oregon Public Health Division, Oregon Death With Dignity Act: Data Summary 2020. Available from:

https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

- Loss of dignity
- Burden on family, friends and caregivers
- Losing control of bodily functions.

Notably, neither pain nor fear of pain appears in the top reasons.[25]

Financial burdens of treatment are an increasing factor

The financial burdens of treatment are now being cited as a reason death is being requested in Oregon's official statistics around assisted suicide.[26] There are also anecdotal stories of those suffering chronic but not terminal conditions in Canada seeking euthanasia because they cannot afford treatment.[27] Researchers in Canada determined that the legalisation of euthanasia "could reduce annual health care spending across Canada by between $34.7 million and $138.8 million."[28]

Doctors are very rarely prosecuted for breaches

No doctor has been successfully prosecuted for violating a safeguard in the Netherlands, despite regular breaches of the law being recorded by the Euthanasia Commission. In the first two years of legalised euthanasia in Quebec, 62 deaths (5.6 percent of all euthanasia deaths) were deemed by the Commission on End-of-Life Care to have been a result of abuse by the doctor who prescribed and administered the lethal injection, but none was recommend for prosecution.[29]

Conscience rights are attacked

The *Voluntary Assisted Dying Bill 2021* proposes no right for institutional conscientious objection for aged care facilities, meaning that no one will be able to choose to live in a facility where euthanasia is not practiced. In Canada, similar provisions have seen even small, non-profit hospices shut down. The Irene Thomas Hospice in Vancouver, a palliative care facility with only ten beds, was forced to close after refusing to allow euthanasia. The local health authority evicted the operators, even though a facility to which patients could be transferred was located just 300 metres away.[30]

Conclusion

For the reasons articulated above, we are strongly of the view that this Bill must be rejected by the NSW Parliament. It cannot guarantee that wrongful deaths will not occur, and it represents a

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[25] Ibid.

[26] Ibid

[27] Wyton M. 'I shouldn't have to beg for my life.' The Tyee. 5 July 2021. Available from: https://thetyee.ca/News/2021/07/05/I-Should-Not-Have-To-Beg-For-My-Life/

[28] Trachtenberg AJ, Manns B. Cost analysis of medical assistance in dying in Canada. CMAJ. 2017;189(3):E101-E105. doi:10.1503/cmaj.160650

[29] Martin A. Two years of euthanasia in Quebec: the facts. Mercatornet. 11 Dec 2017. Available from: https://mercatornet.com/two-years-of-euthanasia-in-quebec-the-facts/22702/

[30] The Canadian Press. Patients must transfer as Fraser Health takes over Delta hospice. Vancouver Sun. 7 Feb 2021. Available from: https://vancouversun.com/news/local-news/patients-must-transfer-as-fraser-health-takes-over-rogue-delta-hospice

fundamental abrogation of the duty of government to govern for all its citizens, particularly those who are especially vulnerable due to old age, illness, disability, infirmity or other reasons. It is therefore fundamentally unsafe and is not in the best interests of people living in NSW.