Submission No 53

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Organisation: The Presbyterian Church of Australia in the State of NSW

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Submission to

Standing Committee on Law and Justice of the NSW Legislative Council regarding Voluntary Assisted Dying Bill 2021.

From

The Presbyterian Church of Australia
In the State of NSW

PO Box 2196, Strawberry Hills, NSW, 2012

Who we are

The Presbyterian Church in Australia in the state of NSW (PCNSW) consists of 186 pastoral charges spread through NSW. It is a community of about 35,000 people and has congregations from nine different non-English speaking cultures. Beyond its congregational ministries, the PCNSW operates schools, aged care facilities, pre-schools and provides social services and chaplaincy care in a wide range of communities in the state. The Presbyterian Church has been part of NSW society since 1803, and helped to form the Presbyterian Church of Australia in 1901.

This submission has been prepared by the Gospel, Society and Culture Committee of the PCNSW Assembly. For further information contact the convener of the committee, Rev. Dr. John McClean.

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Our Position

The Presbyterian Church in NSW has consistently opposed the legalization of voluntary euthanasia, physician assisted suicide or voluntary assisted dying (VAD). We hold that human life is uniquely precious and that our society should protect and preserving it by providing excellent care for those in pain and facing death. Offering the opportunity for patients to end their lives prematurely subverts that commitment and opens possibilities for vulnerable people to feel pressure to accept VAD. The proposed Bill lacks some necessary safe guards.

Our Reasons

1. Christian convictions

The most recent Assembly of the PCNSW in July 2021 considered the issue of VAD. Its resolutions set out the Church's ethical opposition to any legalisation of euthanasia.

The Assembly resolved that "the biblical principle of the sanctity of human life expressed in the sixth commandment (Exodus 20:13) is God's protection of human life and prohibits ending a human life to relieve pain". This has been the classical view of Christian churches. It is based in the teaching of the Bible that humans are created in God's image and that human life is especially protected by God and that humans are held to account for the lives of our neighbours. This conviction has been the basis for many Christian innovations for social justice as well as the development of medical care by many people with Christian motivation. Sadly, Christians have not always acted consistently with this conviction. Nevertheless, it has been one of the most signification contributions of Christianity to the world and has provided an ethical basis for many of the rights which we treasures in our society.[1]

The Assembly confirmed the importance of palliative care which reduces pain and suffering and allows people to prepare well for death and to die with dignity. Modern palliative care had its origins in hospices established by churches in England in the late 19th century to provide for the medical, nursing, and spiritual needs of those who could not afford care from private physicians.[2] The basis for many of the

[1] See David P. Gushee, *The Sacredness of Human Life: Why an Ancient Biblical Vision Is Key to the World's Future* (Eerdmans, 2013).

[2] Clare Humphreys "Waiting for the last summons": The establishment of the first hospices in England 1878-1914, *Mortality*, 6:2 (2001: 146-166, DOI: 10.1080/13576270120051875a

clinical practices of modern palliative care were developed by Dame Cicely Saunders (1918-2005) a nurse, medical social worker and physician. Saunders Christian convictions led her to advocate that the care of the dying was an important part of total healthcare. Her holistic view of patients promoted her to develop the "total pain" theory which recognised that pain, especially at the end of life, can arise from physical, psychological, social and spiritual sources.[3] In Australia, "by the early 1970s, three major providers accounted for most hospice services in Australia: the Little Company of Mary; Sisters of Charity; and the Deaconess Society". Each was, notably, a Christian service.[4]

The inclusion of VAD in medical care subverts the focus of medical professionals from sustaining life and providing care. It may also undermine the confidence of patients and families in the medical system and its staff, if they perceive that staff advocate for VAD.

The Assembly clarified that "the prohibition of ending human life does not oblige a patient with a terminal condition to receive medical interventions which extend life". Patients should be empowered to make informed decisions about the type of care they receive and should not be expected to undergo burdensome treatments.

Finally, the Assembly expressed this concern that the legalisation of VAD entails the risk that vulnerable people will be pressured to seek or allow VAD. There are risks that family members or medical staff may deliberately place pressure on patients to

[3] J. Dobson, "Dame Cicely Saunders - an inspirational nursing theorist." *Cancer Nursing Practice* 16.7 (2017): 31

[4] D.C. Currow & J. Phillips, J. "Evolution of palliative care in Australia 1973-2013". *Cancer Forum*, 37.1 (2013), 38-42.

accept VAD. More likely, vulnerable people may consider that VAD is the best option for them to avoid being a "burden".

2. Concerns about the provision of Voluntary Assisted Dying Bill 2021.

Along with our ethical objections to euthanasia, we have particular concerns about the current Bill.

- Health care workers will be permitted to suggest VAD to a patient.

This is not allowed under the Victorian legislation. It may allow heath care staff to influence patients to consider VAD. Although staff may consider the suggestion benign, it is very possible that a patient will receive it as clinical advice and find it difficult to express their own preference.

- There is no provision that a serious mental illness (including clinical depression) would prevent a person from accessing VAD.

The 2017 Bill contained the wise provision that a patient considering VAD was to be examined by a qualified psychologist or psychiatrist. Requests for VAD may spring from depressive and/or anxiety symptoms which could be treated effectively.

- The doctors involved have to determine the patient's prognosis, but neither has to be a specialist in the patient's condition, nor in palliative care, nor does either of them have to be the person's regular doctor.

The 2017 Bill required that a patient be offered a referral to a palliative care specialist. Under the provisions of the current bill, the medical oversight of VAD

requires no specialisation from the doctors nor any close knowledge of the patient and their case.

- Doctors can take the request for VAD via telehealth, which means that they could approve VAD for a patient they have not examined.

This will reduce the opportunity for the doctors to diagnosis mental illness and to discern the possibility that the patient is being pressured or coerced. It is very likely that doctors, medical staff and patients will opt for relatively perfunctory telehealth consultations, rather than a more demanding face to face consultation and examination.

- The legislation allows a minimum time gap of 5 days between the requests for VAD.

This allows little time for serious reflection by the patient and the family, or for them to explore and receive palliative care or mental health treatments.

- Aged care facilities, including faith-based facilities, will have to allow health professionals on-site to conduct every step of the VAD process.

Although the legislation protects individual practitioners from being required to participate in VAD and protects private hospitals from being required to provide facilities for VAD, it does not extend the same protection to aged care facilities.