Submission No 79

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Organisation: The Greek Orthodox Archdiocese of Australia

Date Received: 22 November 2021

† Archbishop Makarios of Australia

Protocol No.: **1704**

Mr Dave Layzell MP
Legislation Review Committee Chair
Legislative Council Standing Committee on Law and Justice
Parliament of New South Wales
Parliament House
Macquarie Street
SYDNEY NSW 2000
Sent via email: legislation.review@parliament.nsw.gov.au

Dear Mr Layzell,

Subject: **Submission to the Legislation Review Committee on Law and Justice into the *Voluntary Assisted Dying* Bill 2021**

We refer to the Legislative Review Committee review of the *Voluntary Assisted Dying Bill 2021* (NSW) ("the Bill") and appreciate the opportunity to make a submission as a testimony to the dignity and value of all human life.

Firstly, we express in the strongest possible terms, our heartfelt pain and distress at the introduction of this Bill.

The Orthodox Christian Faith and Tradition unequivocally teach that our life constitutes the supreme gift from God, the beginning and end of which depend entirely on Him: "in his hand is the life of every living thing" (Job 12:10). It is created by God. It bears the divine image. It is not ours. Our role is to protect this sacrosanct gift in every way possible.

Moreover, a human person is more than their health. Life retains irreducible value even where full health cannot be restored. Sickness is a deep mystery and can only be viewed and appreciated through the prism of eternity. We shall not expound the theological reasons except to say that suffering or anguish is not meaningless.

Since the time of Hippocrates, the medical mission was identified with the provision of therapy and offering of life, and was incompatible with any participation in causing death. According to his famous oath, the physician promises that *"he will never give anyone a deadly medicine, even if he asks for it, nor will he advise him to take it"*.

However, where the physician cannot provide a cure, medical care should be focussed on easing pain and distress by appropriate means.

As such, we strongly recommend palliative care options for persons suffering from a terminal illness, which have developed pain management techniques that are effective, inexpensive and readily available. These should be given the highest priority to guarantee that our final days and hours are able to be spent in a state of alertness with a minimum of physical or mental distress.

Today people talk about *euthanasia,* Greek for a 'good death', but there is a sense of irony in such words. A good death is not only one that maximises the quality of life with minimal suffering but also one that has purpose or meaning.

How we face death is a measure of ourselves, who we are and what we value. It is an opportunity to seek fellowship with family members, friends, and a time to seek reconciliation with God.

Our Parliament has a duty to protect its residents and make laws to preserve life. Euthanasia is intentional killing, and that is a line that should never be crossed.

If Voluntary Assisted Dying is legislated, there are no real effective safeguards against its future abuse of the terminally ill and most vulnerable in our community.

The Bill stands in opposition to the collective conscience of the Greek Orthodox faithful of Australia. Our Church, which also comprises our aged care institutions but more importantly its individual members - precious human beings - collectively voice our opposition to interventions of this kind. I remain,

On the 22nd day of November, 2021
Prayerfully yours

† Archbishop MAKARIOS
Primate of the Greek Orthodox Church in Australia

[This submission should be read in conjunction with a separate submission that addresses more technical aspects of the Bill.]

† Archbishop Makarios of Australia

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We refer to the Legislative Review Committee review of the *Voluntary Assisted Dying* Bill 2021 (NSW) ("the Bill") and appreciate the opportunity for our Archdiocese to make a submission as a testimony to the dignity and value of all human life.

Firstly, we express in the strongest possible terms, the heartfelt pain and distress at the introduction of this Bill.

As Primate of the Greek Orthodox Church of Australia I have outlined separately our Church's position on euthanasia, noting that for this reason alone, the Bill should be defeated.

However, this submission will focus on the provisions of the Bill, noting that the Bill as currently drafted does not afford adequate protections for the person suffering from an incurable terminal illness, leading to unintended consequences.

In no way should this separate submission be misconstrued as endorsing euthanasia.

We these thoughts, I remain,

On the 22nd day of November, 2021
Prayerfully yours

† Archbishop MAKARIOS
Primate of the Greek Orthodox Church in Australia

SUBMISSION OF THE GREEK ORTHODOX ARCHDIOCESE OF AUSTRALIA

New South Wales Legislative Council

Standing Committee on Law and Justice

Voluntary Assisted Dying Bill 2021

November 2021

AN EVALUATION OF THE PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Introduction

This submission on the *Voluntary Assisted Dying Bill* 2021 to be introduced by Alex Greenwich into the NSW Parliament promotes patient autonomy with minimal safeguards. Without significant adjustments to the provisions within the Bill, there are significant risks for:

- Vulnerable people suffering from terminal illnesses unwillingly and/or unwittingly accessing Voluntary Assisted Dying (VAD);
- The medical professionals authorising VAD being sued for negligence in failing in their duty of care;
- The Tribunal or Board in appropriately discharging its obligations.
- The state of NSW for failing to protect the residents of NSW and those that have a conscious objection to VAD.

1. Eligibility

The medical criteria required to access Voluntary Assisted Dying (VAD) in this bill is problematic. Section 16(1)(d) provides that:

> *(d) the person is diagnosed with at least 1 disease, illness or medical condition that—*
>
> *(i) is advanced, progressive and will cause death, and*
>
> *(ii) will, on the balance of probabilities, cause death—*
>
> *(A) for a disease, illness or medical condition that is neurodegenerative—within a period of 12 months, or*
>
> *(B) otherwise—within a period of 6 months, and*
>
> *(iii) is causing suffering to the person that cannot be relieved in a way the person considers tolerable*

The issues and risks associated with this provision is that:

Issue	Risk
Eligibility must be determined by both the person's coordinating practitioner and consulting practitioner.	There is no requirement for the co-ordinating practitioner and consulting practitioner to be independent of each other. A coordinating practitioner is likely to be a doctor working within the pressures of a palliative care ward and lacking the requisite independence to determine eligibility. Consulting practitioners could become 'guns for hire', accepting consulting roles and developing reputations for being either 'euthanasia friendly' or 'slow to approve'.
The regime proposed does not provide for appropriate levels of scrutiny to be applied to the process.	The development of a suicide industry lacking appropriate arms-length oversight and supervision. It is difficult to see how the coordinating and consulting practitioners (not being legally trained) could possibly reach a conclusion that the person is not being unduly influenced or pressured (refer s16(1)(g)). Another factor in support of an independent arbiter.
The test enunciated in s16(1)(d)(iii) is very subjective.	What is tolerable for one person is intolerable for another, leading to the potential abuse unless an appropriate legislative standard is set.

<u>Recommendation</u>

- The co-ordinating practitioner and consulting practitioner must be independent of each other.

- The approval process to access voluntary assisted dying, including eligibility should be determined by a specialist tribunal with rotating chairs occupied by practitioners specialising in appropriate fields of medicine such as pain, palliative care, neurodegenerative diseases.

- In the alternative, the Supreme Court of NSW could be an appropriate original jurisdiction to determine eligibility and associated access issues. Given the few cases that are likely to arise on a year-by-year basis, it is unlikely the Court would be unduly burdened by accepting such jurisdiction.

- Each and every application for access to voluntary assisted dying must involve forensic medical and legal analysis to safeguard against misdiagnoses, 'euthanasia-friendly' practitioners, undue influence, the commercialisation of access, etc. To allow for anything less would be negligent legislating that exposes the regime to abuse.

- All that must be satisfied for the final element of the eligibility criteria is that the person must consider that any relief would not suffice to make their suffering tolerable. In order to prevent the system being abused, there should be a requirement to compel the person to make reasonable attempts to access available forms of relief and / or palliative care options.

2. Assessment Process Issues

2.1 Inadequate knowledge of palliative care and treatment options

One of the 11 principles of the Bill outlined in Clause 4 sub section 1 is that a person has the right to be supported in making informed decisions about all medical treatment options available including comfort and palliative care and treatment.

Clause 18 of the Bill merely requires that a medical practitioner:

- holds a specialist registration or holds a general registration and has practised the medical profession for at least 10 years as the holder of general registration, or is an overseas-trained specialist who holds limited registration or provisional registration
- has completed the approved training

The issues and risks associated with this provision is that:

Issue	Risk
The medical practitioner co-ordinating or approving VAD is	The risk is that people may be accessing VAD by not having access to the full range of leading practice

not required to have the requisite experience in the person's terminal illness.	options on how to alleviate their physical and mental pain. The majority of people who access VAD in jurisdictions where it has been legalised are diagnosed with a form of cancer. Therefore, coordinating practitioners who are not oncologists are at a significant disadvantage to advise a person on the most up to date options available to help a person make a fully informed choice about treatment options including comfort and palliative care.

Recommendation

- The medical practitioner co-ordinating or approving VAD must have significant experience in the terminal medical condition.

2.2 Inadequate consideration of mental health on decision making capacity and voluntariness

There are no safeguards in the Bill to ensure that during the assessment process the mental health of a person is not adversely impacting their decision-making capacity.

Stringent safeguards around mental health and decision-making capacity are required because mental health conditions like depression, anxiety and demoralisation may be exacerbated when life threatening diagnoses are involved and commonly lead to suicidal thoughts.

Recommendation

- The mental health of a person making a request for VAD must be assessed by an appropriately qualified psychiatrist, ensuring that a person's decision-making capacity is not being adversely impacted because of their mental health. For example, where a patient has cancer, psycho-oncological professionals are often the most appropriate practitioners to make an accurate diagnosis as to the persons mental health.

- A person should participate in a holistic comfort care program that covers medical, palliative, pastoral, pain, psychological and psychiatric dimensions of a

terminal illness prognosis, enabling them to be better positioned to make an informed decision.

Below are some quotes from general and specialist practitioners on this topic.

"Some cancer patients have survived for years despite a prognosis of several months. With a strong will to live encouraged by positive medical/palliative/pastoral/pain/psychological and psychiatric care they were able to cheat death and live a fulfilling life".

"Some such patients with their suffering, chemo brain, possible mental illness and depression are vulnerable, scared, unsure, cognitively impaired not knowing what to do. The last thing they literally require is a push in the wrong direction".

"This death movement, unspoken pressure as well as ageism and promotion of this option may make these patients contemplate this final act without full understanding. Doctors who have seen medicine as a helping treating profession may be entangled in aspects of this bill which could diminish their practice dedicated to restoring health and preserving life and doing no harm".

2.3 Person withholding of information from doctors

For a person seeking VAD, there are minimal safeguards to ensure that information that informs a practitioner's diagnosis is accurate.

While some conditions may be objective, others are not and factors may not be known to either the coordinating or consulting practitioner when they conduct their assessments. Pain, one of the key criteria for obtaining VAD, cannot be tested objectively and relies on interactions with a patient. The practitioners who see the person seeking VAD may be meeting the person for the first time when they assess them.

There are also instances of victimhood, domestic abuse and elder abuse that would not be known to a practitioner and may not be revealed by a person seeking VAD. All of these factors could see people subject to VAD who have seen their decision-making capacity overborne, or who are subject to pressure or duress.

While rejections of the provision of VAD due to factors of decision-making capacity, voluntariness and pressure/duress are able to be challenged at the NSWSC (s 109(1)(a)), there is no provision for interested parties to be able to challenge to

prevent VAD from occurring because any of the above criteria listed at s 16(1)(e)-(g) are not met.

Recommendation

- The VAD request should be determined by a specialist tribunal with rotating chairs occupied by practitioners specialising in appropriate fields of medicine such as pain, palliative care, neurodegenerative diseases.

- In the alternative, the Supreme Court could be an appropriate original jurisdiction to determine eligibility and associated access issues.

2.4. Information gaps that arise from the potential exclusion of family, carers, GPs and other health care professionals

There is no requirement for a person seeking VAD to disclose their medical history to either of the practitioners who are to assess the person. There may be aspects of a person's recent medical history that are unknown to the practitioners assessing the person, or the person themselves, that may be known to other doctors or specialists who have seen the person in the recent past. While sections 25(3) and 36(3) do not prevent either of the practitioners from obtaining other medical opinions or records, there is no obligation to do this.

In a similar vein, when a person seeking VAD meets the eligibility criteria in s 28(1), there is no enforceable obligation for the patient to consult a medical practitioner from whom they are receiving ongoing medical services. By the time it is known that this obligation has been breached, the person may already have undergone VAD.

Recommendation

- Each and every application for access to VAD must involve forensic medical and legal analysis to safeguard against misdiagnoses, 'euthanasia-friendly' practitioners, undue influence, the commercialisation of access, etc. To allow for anything less would be negligent legislating that exposes the regime to abuse.

3. Limited oversight by the Board and the Tribunal

The Bill proposes to construct a system through which the Board may oversee the voluntary assisted dying procedure. However, the scope of its involvement is, for

the most part, limited to the documented dialogue between the coordinating and consulting practitioner and the patient.

The Bill fails to implement an appropriate framework from which the Board may gauge the 'full-picture' of the patient's physical and mental health, and most especially the patient's capacity and/or degree of voluntariness exercised in respect of their decision.

The purpose of the Board would be to refuse, approve or disapprove authorisations for voluntary assisted dying substance prescriptions per Section 71-72.

Section 72(1)(b) imposes an obligation on the Board where the Board must refuse to issue an authorisation in cases where "the Board suspects that the requirements of this Act have not been met in relation to the patient."

In order for the Board to discharge its obligations, it must have access to, and be able to receive, all relevant information that is poignant to "the requirements of the Act" with respect to each patient's case.

While section 108(c) allows an "eligible applicant" to make application to the Supreme Court where the "eligible applicant" has "a sufficient and genuine interest in the rights and interest of the patient", the Bill does not further define what a "sufficient or genuine interest" is.

<u>Recommendation</u>

- Prior to the Board approving the VAD procedure, the Board must be compelled to gather information and evidence from individuals, including and not limited to:
    - the patient's family;
    - carers;
    - past and present treating health practitioners; and
    - independent specialist medical practitioners.

  It is reasonable to expect that these other individuals may have objective and subjective knowledge or information that would present the patient's case in a different light. Excluding these people from the process would significantly hinder the Board's ability to make the correct decision, particularly in cases where it ought to be aware of certain facts (such as unlawful, or illegal activity) that would necessitate the Board to refuse authorisation.

- Individuals who possess information essential for the Board in its decision making, or otherwise relevant to the case, ought to have standing to submit their information to the Board and the Board must be compelled to accept this information and give it due consideration.

4. Institutional Conscientious Objection

Part 5 of the Bill imposes obligations on hospitals and care facilities to provide the following:

(a) information about voluntary assisted dying,
(b) facilitate the request and assessment process for voluntary assisted dying,
(c) the administration of a voluntary assisted dying substance; and/ or
(d) information about the fact that the entity does not provide services relating to voluntary assisted dying at the residential facility, private health facility or public hospital.

A hospital or aged care facility can make provisions for patient transfer if they wish to seek assessment for or access to assisted suicide or euthanasia at another institution or location.

Recommendation
Facilities or persons within these facilities should be under no obligation to provide a patient with access to any part of the process on their grounds or be required to assist in the eligibility assessment or the administration of voluntary assisted dying.

5. Other Concerns about the NSW VAD Bill 2021

Part 5.1: Increased risks of crimes associated with self-administration decisions

One of the options available under the Bill is for a patient to "decide to self-administer a voluntary assisted dying substance": cl. 57(1)(a). If this option is chosen, the patient must appoint a "contact person" (cl. 66(1)) who is authorised to (cl. 68(1)):

- receive the prescribed substance;
- possess the prescribed substance;
- prepare the prescribed substance for self-administration by the patient; and
- supply the prescribed substance to the patient.

Those express powers and authorisations make clear that the "contact person" will have knowledge of where the prescribed substance – i.e. a poison which causes rapid death - will be stored and will be permitted to possess that substance. In the wrong hands, the contact person has ready access to a potential method to bring about the patient's death without their consent (e.g. if the patient decides that they no longer want to proceed).

Recommendation

Bill should contain strong safeguards regarding who can be a "contact person". Currently the only restriction on who can be a "contact person" is that they must be an adult: cl. 66(2).

The Bill must be amended to exclude someone who:

1. will benefit directly or indirectly from the patient's death; and/or
2. has a prior history of abusive or criminal behaviour (e.g. no police check is performed).

The above are the most basic and obvious exceptions. The consequence of this fact is that the Bill does not prevent the patient from choosing a contact person who might have a motive to hasten the patient's death with a relatively accessible method that will most likely not be investigated by the police or by a coroner.

This also undermines some of the other 'protections' that the Bill seeks to have in-place, as an unscrupulous family member could readily put pressure on an elderly relative to elect to self-administer and have them appointed as contact person.

Part 5.2: Initiation of discussion regarding voluntary assisted dying

The common law of Australia presumptively recognises the influence that a physician has on his/her patient. This is a matter of common experience, particularly when the patient involved is vulnerable by reason of their condition or suffering. Accordingly, one of the most fundamental protections that must exist in any regime regarding voluntary assisted dying is ensuring that the decision to commence the journey towards death is made entirely by the patient, without any suggestion or influence by the practitioner.

Against this context, cl. 10 of the Bill is titled "Health care worker not to initiate discussion about voluntary assisted dying". Despite the apparent clarity of the

heading, cl. 10(2) deprives the clause of most of its force by permitting a medical practitioner to initiate a discussion regarding voluntary assisted dying so long as that medical practitioner also informs the person about their treatment and palliative care options.

This is an inadequate protection in circumstances where the nature of potential treatments for cancer or neurodegenerative conditions are complex, and the options for palliative care not well known. Accordingly, there is a real risk that the registered practitioner will have insufficient expertise to accurately advise on the options available to the patient. This concern is exacerbated by the fact that the advising practitioner is not required to be a specialist in the area of the patient's illness.

Part 5.3: Slow deaths or complications with assisted suicide/euthanasia

The Bill also fails to consider the possibility of the patient dying slower than expected, or complications arising where the assisted suicide poison is ineffective. Therefore, attention will need to be given to what a satisfactory response would look like from an administering practitioner in this situation and whether nurse practitioners or registered nurses have adequate training, skills or authority to deal with this situation when it arises. This is relevant as cl. 55(a)(iv) &(v) of the Bill allows for a nurse practitioner or a registered nurse with 5 years' experience to act as an administering practitioner in administering a voluntary assisted dying substance to patients.

This issue was touched on in a recent study by Zworth et al which details how administering practitioners deal with deaths that are "taking too long". It was found that the approach of administering practitioners was to use neuromuscular blockers (NMBs) (which are commonly in anaesthetics) to accelerate the person's death. The study also indicated that knowledge and administration of NMB's is quite specialised and normally guided by medical devices that can help monitor the patient to control dosage levels. Therefore, concern is raised over whether nurse practitioners or registered nurses would be equipped to handle this situation when it arises.

There are also no provisions in the Bill that require the administering practitioner to preserve the life of the patient in the event that there are complications. One of the main complications that arise from the ingestion of barbiturates (that would be part of the self-administration process) is pulmonary edema. Pulmonary edema is a serious health condition that will require a high level of first aid skills and require rapid hospitalisation and intensive care attention. The likelihood that a nurse

practitioner or a registered nurse could deal with this situation at a person's home is again, questionable.

University of Otago bioethics researcher and palliative care physician Dr Janine Winters presented an international literature review to the Ministry of Health in February 2021. It included a recent study from the Netherlands where in 21 of 114 cases, the patient did not die as soon as expected or woke up and the physician had to give a lethal injection. This raises other legal and ethical concerns such as whether the patient would have to give consent again and be re-examined if hours or days go by between doses. This is one of a very long list of difficult and troubling issues that can be expected to occur without further guidelines and safeguards.

Part 5.4: Use of Audio-visual communication links

Notwithstanding the issues surrounding the negative impact that audio-visual communication links will have on the assessment of the eligibility criteria, there also remains a question as to whether this practice is even legal and whether the NSW practitioners will be at risk of prosecution if the Bill is passed.

The Victorian Voluntary Assisted Dying Review Board released its Report of Operations for January – June 2020 in September last year. The report highlighted that due to s474.29A and s474.29B of the Commonwealth Criminal Code 1995 as amended by the Criminal Code Amendment (Suicide Related Material Offences) Act 2005, it is an offence to use a 'carriage service' (the internet, emails, mobile and fixed telephones, faxes, radio and TV) for the purposes of counselling or inciting suicide, or promoting or providing instruction on a particular method of suicide. Possession or supply of material that is intended to be used for such offences is also itself an offence. This raised debate as to whether this provision extended to include voluntary assisted dying - assisted suicide.

There is room for disagreement about whether and when health professionals who use a carriage service to discuss voluntary assisted dying will contravene these laws. One threshold issue is whether voluntary assisted dying meets the legal definition of 'suicide' i.e., 'intentional self-killing'. There aren't strong arguments of logic why the two concepts are distinct, but a court has never ruled on whether voluntary assisted dying meets the legal meaning of suicide under the Code, creating significant legal uncertainty.

In response, the Federal Attorney General, Christian Porter said that it was a requirement of the Victorian legislation that consultations occur in person and so

there seems no conflict with Commonwealth offences relating to inciting or instructing suicide online. However, the current proposed Bill as it stands explicitly promotes the option for doctors to use an audio-visual link for consultations, which can be seen in clauses 3(2)(d), 51(2)(e) and 183. Therefore, the proposed new NSW laws would place medical practitioners at risk of prosecution.