Submission No 92

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Name: Dr Stephen Parnis

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

I thank the committee for the opportunity to make a submission.

I have been a medical practitioner for 28 years, and a specialist emergency physician for 15 years. I have participated in the care of thousands of people as they have approached the end of their lives. I have witnessed many who have died well, and regrettably, many who have died in circumstances that could have been far better.

I have served in leadership positions with the Australian Medical Association for over a decade (2004-2016). In those roles, particularly as State President of AMA Victoria (2012-14), and as Federal Vice President of the AMA (2014-16), I established as an organisational priority the need for improved End of Life Care (EOLC) within Victoria and nationally.

I contend that for many reasons, Australians have, over decades, become progressively more quarantined from death. As a consequence, our attitudes have become more fearful, and our expectations of medical care (in providing cure where none exists, or in failing to recognise the dividing line between beneficial care and harmful treatment) are often unrealistic.

I applaud efforts across the health system and government to enhance EOLC

- improved awareness of a person's values and desires as they near the end of their life
- the urgent need for improved palliative care at almost every level
- better training for health professionals in the provision of EOLC

Having said that, I state without hesitation that I regard any resort to the provision of a regime which enables Assisted Suicide & Euthanasia (AS&E) as naïve and dangerous.

I assert that there is a world of difference between the provision of effective, authoritative and urgent palliative care, and the act of prescribing or administering drugs with the intention of immediately taking human life.

I reject the term Voluntary Assisted Dying as used by proponents of AS&E. It is an attempt to sanitise and divert attention away from the more descriptive and accurate terminology which refers to someone taking their own life, which we rightly deem unacceptable in every other context. Drawing an arbitrary distinction between suicide in this context and every other circumstance is dangerous and misguided.

The case for AS&E is often presented as a choice between standard medical (palliative) care and a rapid, painless and dignified exit for someone who has no hope of survival. I contend that this is seriously in error on many levels:

- palliative care in Australia is widely unavailable, delayed in its implementation, and even less likely to be utilised by millions of disadvantaged Australians.
- AS&E regimes in other parts of the world have never been able to guarantee the painless exit that many claim
- An understanding of the concept of human dignity at the end of life should relate to the provision of care and comfort, not the blunt assertion of one's right to kill themselves, irrespective of the harm they may do to those around them

The issue of public opinion is important. Proponents of AS&E routinely state that huge majorities support them. I say that the details matter:

- If the question were "Do you want to be able to determine the circumstances which would enable you to die in comfort, at a place and circumstance of your choosing?", I would hope the answer is 100%. If that could be delivered by the sort of palliative care system and culture I advocate, then support for AS&E would be a less supported proposition
- If the risks and unintended consequences of AS&E were openly acknowledged (which can be summarised as wrongful deaths), the level of public support would fall away even further
- My profession is far less supportive of AS&E than the general population, and it would be salutary to reflect on the reasons for this. Greater familiarity with the dying process, critical appraisal of meaningful evidence, and better access to palliative care are pertinent

As an emergency physician and leader within my profession, I have spent many years assessing and dealing with complex systems, with the aims of improving the safety, efficiency and quality of health care. Equally, it is about minimising harm and risk. The more complex the system, the greater the risks to those entering it. In Victoria, a regime which trumpets more than 60 specific legislative safeguards should be regarded as a system where there are more than 60 opportunities for error. Such errors include:

- Misdiagnosis and gross error in determining prognosis
- Undiagnosed mental illness
- Coercive pressure upon those who feel they are a burden

I oppose AS&E on the grounds of social justice. Social justice is founded on the principle of protection of the vulnerable, and the dying are among the most vulnerable in our society. As Lindsay Tanner stated in the House of Representatives in 1996, "I am troubled by euthanasia because I think it is virtually impossible to draw safe boundaries, because I think it is virtually impossible to prevent abuses and mistakes and because I think it is virtually impossible to justify offering the option of assisted suicide to one category of people when you deny it to others."

As a nation, we have been traumatised by a Royal Commission's revelations of the abuse of children in circumstances where we had previously trusted that they were safe. We have learnt a painful lesson. We have now witnessed three further Royal Commissions to investigate the mistreatment of the Disabled, those in Aged Care, and the Mental Health System (Victoria). The message should be clear – as a society, we have an abysmal record when it comes to regulatory protections of vulnerable groups. To now establish a system which allows for the state-sanctioned death of such vulnerable citizens, merely opens the door to further abuses. How many wrongful deaths are acceptable in order to satisfy the demand of someone to take their own life legally?

Medical ethics are founded on doing good for the patient (beneficence), and not to harm them (non-maleficence). Killing a patient or providing the means for them to do so can never be sanctioned by these ethical principles. It is on this basis that the first statement in the AMA's position statement on EOLC states that "The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life".

Victoria's regime for legalised AS&E commenced operation on 19 June 2019. In 2016, the Victorian Parliamentary Committee of Inquiry indicated that there were significant gaps in palliative care in that state, and Palliative Care Victoria has repeatedly stated that there is an annual $65m funding shortfall in palliative care service delivery. The Victorian Government has spent considerable resources since 2017 establishing legalised assisted suicide services. This money should have been spent improving palliative care, and it is a perverse outcome. If high quality palliative care is well funded and readily available, then I would assert the demand for assisted suicide is dramatically reduced. It has been readily acknowledged in the recent Queensland debate that palliative care provision remains critically under resourced. To proceed with an assisted suicide regime while palliative care is heavily underfunded is indefensible health policy.

I close with the words of Senator Dodson, who made this contribution to the Senate in August 2018, in response to an attempt to enable Territory Parliaments to legislate for assisted suicide and euthanasia. He said, "If we give one person the right to make that decision—that is, to assist in committing suicide—we as a whole are affected. If we give one family that right, we as a whole are affected. If we give one state or territory that right, we as a country are affected. If we give one nation the right to determine life, our common humanity is affected. I cannot support this legislation."

Thank you for your consideration. I would welcome the opportunity, in addition to this submission, to provide oral evidence to the committee.

Dr Stephen Parnis MBBS DipSurgAnat FACEM FAICD FAMA

Consultant Emergency Physician, St Vincent's Hospital, Melbourne & Royal Victorian Eye & Ear Hospital

Former President, AMA Victoria, & Former Vice President, Australian Medical Association