Submission
No 95

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Organisation: Plunkett Centre for Ethics

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Plunkett Centre for Ethics

A joint centre of Australian Catholic University, St Vincent’s Health Network Sydney, Calvary Healthcare

Submission to
NSW Legislative Council's Standing Committee on Law and Justice
on
Voluntary Assisted Dying Bill 2021

1. Introduction

1.1. I am director of the Plunkett Centre for Ethics, a joint centre of Australian Catholic University, St Vincent’s Health Network Sydney and Calvary Healthcare. The Plunkett Centre promotes the values of compassion and fellowship, intellectual and professional excellence, and fairness and justice. Its primary focus is on the realisation of these values in the provision and the allocation of health care. The Centre expresses this commitment through research, teaching and community engagement, and by bringing a Catholic perspective to all its endeavours. I represent this Centre in making this submission.

1.2. In making this submission, I should draw the Committee’s attention to two facts about our bringing a ‘Catholic’ perspective to all our endeavours. First, any reasonable religion holds out its social teachings as matters apt for rational assessment. But, second, there is nothing distinctively religious in my submission. Some people of no faith, and some people of other faiths, may agree with part or all of what I submit. Some people of no faith, and some people of other faiths, indeed some people of my own faith tradition, may disagree with part or all of what I submit.

1.3. I recognize that some people in NSW die badly, suffering from (a) pain and/or other symptoms of illness, (b) ‘existential distress’, or (c) from both. Often a sharp distinction cannot be made between these different forms of suffering.

1.4. That some people die in unrelieved pain or other physical symptoms of illness or frailty is a matter of great shame for our community. There must be various explanations for this (including lack of access to palliative medicine and care, inferior end of life treatment and care, the imposition of futile or overly-burdensome treatment, the failure to respect refusals of life-prolonging treatment, the failure to use all the therapeutic means available to relieve pain and other symptoms that are proper to the practice of medicine at the end of life, the insistence of families who want 'everything' to be done, etc). All of these factors need attention – from the medical profession, from the administrators and funders of healthcare, from the parliament, if we are to ensure that everyone dies well. But that goal, that everyone is able to die well, is perfectly achievable without the legalization of doctors assisting people to take their own lives. That is to say, in order to ensure that everyone in NSW dies free of pain and other symptoms of illness, frailty, etc, we do not need to legalize doctors assisting suicide.

1.5. As for existential distress - loneliness, the fear of being a burden on others, boredom, alienation from others, etc: these are not properly the objects of medical treatment. Of course, a good doctor will be attentive to them, and (working with others) do what he or she can to alleviate them. These experiences are part of the human condition. They constitute challenges to us, individually and collectively, to do what we can to be effectively responsive to people who suffer in these ways, to 'heal' their suffering in ways other than assisting them to end their own lives.

2. **For four reasons, I urge the Committee totally to reject this Bill:**

   2.1. The Parliament should not destroy the cornerstone of law. '*Society's prohibition on intentional killing… is the cornerstone of law and social relationships. It protects each of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia.'* Thus the Select Committee of the English House of Lords in 1994. The most fundamental way of respecting the equality of worth of every human life is to refuse to deliberately end a human life (whether the request for deliberately ending the life comes from the person himself or herself or from others).

   2.2. The Parliament should not legalize a practice that predicably, inevitably and logically will be 'made available' (expanded) to the frail elderly, the cognitively impaired, the comatose, etc. In every jurisdiction in which this practice has been legalized, the eligibility criteria have been expanded for entirely understandable reasons. [1]

   2.3. The Parliament should not legalize any form of 'medicalized ending of life'. Once that is legal in some circumstances (such as those envisaged by the Bill), the argument will be made, as it has been made, that 'medicalized ending of life' should be available in other circumstances: for example: (a) Hollands's Groningen Protocol for medicalized ending of the lives of disabled newborns; (b) Canada's dropping of the requirement that death be reasonably foreseeable because, it is said, it discriminates against people with serious disabilities who are not terminally ill.

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[1] See Appendix

2.4. Once doctors are authorized to end the lives of patients, <u>the special nature of the doctor-patient relationship,</u> as envisaged in the Hippocratic Oath as that between a person seeking therapy and a person offering therapy, will be corrupted. The Parliament should not legalize a practice which undermines medicine's therapeutic ethic- its promise to work with patients to restore and maintain their health and health-related well-being – even as they die. In order to appreciate this point, it is important to understand a key distinction between deliberately ending a patient's life and (under certain conditions, allowing a patient to die sooner rather than later).

2.4.1. It is consistent with medicine's therapeutic ethic (under certain conditions) to allow a patient to die. It is inconsistent with this ethic for a doctor intentionally to end a patient's life or to help the person to take his or her own life.

2.4.2. In allowing the patient to die, the doctor removes an intervention that forestalls or ameliorates a pre-existing fatal condition or refrains from undertaking one that would forestall/ameliorate a pre-existing fatal condition. This is consistent with medicine's therapeutic ethic.

2.4.3. Thus, the withdrawal of life-sustaining therapy that has been refused by a patient (or by the patient's representative) is an act of allowing to die, not an act of deliberate ending of life, even if the act accelerates the moment of the patient's death. This is consistent with medicine's therapeutic ethic.

2.4.4. In intentionally ending the patient's life, or helping the person to take his or her own life, the doctor creates (or helps to create) a new pathology with the specific intention of thereby causing the person's death. This is not consistent with medicine's therapeutic ethic.

3. Accordingly, for the reasons outlined above, I urge the Parliament of New South Wales totally to reject the *Voluntary Assisted Dying Bill 2021.*

4. In addition, I would like to draw your attention to the following points:

4.1. Re terminology

4.1.1. The claim by the Queensland Law Reform Commission that the term 'voluntary assisted dying' is viewed as providing a more accurate description of the circumstance' is tendentious. A description of the act of self-administering a lethal substance is properly described as 'suicide' whether its circumstances are either unassisted or assisted. The proponents of this Bill understandably wish to distinguish assisted suicide from unassisted suicide. No doubt the circumstances differ. But the act itself remains the same whatever the circumstances. So it is possible that the QLD Law Reform Commission has made an honest mistake. The other possibility is that the Commission endorses the value, to the advocates of this Bill, of the euphemism.

4.2. **Re Principles**

4.2.1. The claim that the principle that 'every human life has equal value' underpins the powers and functions of the Bill is false: it does not. The Bill in fact abandons that principle and adopts a different principle: that the lives of some people are not worth protecting. That judgment, initially made by an individual, will now lawfully be endorsed by the judgments of two doctors.

4.2.2. The claim that 'a person's autonomy, including autonomy in relation to end of life choices, should be respected' is either false or vacuous. For one thing, there are all kinds of choices that the law reasonably prohibits. For another, it is part of the ethic of medicine that a patient's refusals are to be respected. Are we really to believe that the choice of the patient who 'chooses' antibiotics for the common cold is to be respected?

4.2.3. A striking omission is the principle that everyone, regardless of location, is entitled to effective palliative treatment and care, particularly at the end of life.

4.3. Re eligibility criteria

4.3.1. These criteria should be recognized for what they are: sufficiently restrictive to engage the support of parliamentarians. Parliamentarians have no legitimate reason to think that the restrictions will survive even the first review of the Bill, should it be enacted. Once the Bill is passed, several forms of pressure to relax them will emerge, as they have everywhere that this kind of Bill is enacted: the nature of the condition from which the person is suffering, the proximity of death, the voluntariness of the request. Indeed, the proponents of the Bill should be asked, as a guarantee of their bona fides, to confirm that they would oppose any relaxation of these criteria.

4.4. **Re the process.**

4.4.1. As described, two doctors who have no prior knowledge of or relationship with the patient can authorize the administration of a lethal substance. So, if the Bill is passed, initially just a few doctors will become known as available for this service. But then gradually the law, enacted by this Parliament, will have its characteristic 'educative' effect: more and more (young) doctors will come to think of this as a part of authentic healthcare. And so will our medical profession be corrupted.

4.5. Re safeguards.

4.5.1. On the one hand, the safeguards won't be necessary for the few 'rational and autonomous' patients. They know what they want and hardly need protections. On the other, the safeguards will be inadequate and ineffective for those who really need them: those frail elderly people who have already absorbed the fact that they are a burden to their family, whose family are waiting to inherit, etc. No 'safeguards' can protect them. And there is no way that any illegal practice by a doctor could be detected.

4.6. Re conscientious objection.

4.6.1. The Bill acknowledges the public interest in not coercing the conscience of a doctor. It does not adequately acknowledge the public interest in respecting the values of institutions whose ethic of care is based on a different view of the inherent worth of every human being and a different view of what constitutes good end of life care.

5. Suggested amendments to lessen the disvalue of the Bill

5.1. Adopt the more truthful language of Americans on both side of this debate: ‘physician assisted suicide’.

5.2. Limit the Bill to physician assisted suicide. Exclude from the Bill the legalization of a doctor administering a lethal substance to a person.

5.3. Prohibit the doctors from initiating a discussion of VAD. In the past, when patients could be confident that their doctor wouldn’t suggest deliberating end life to their patients, there was no need for this prohibition: sensitive doctors could, in a wide ranging discussion, ask their patients whether they had ever contemplated suicide. This was a normal part of a compassionate conversation with a patient who seemed depressed or demoralized or anxious or suffering from ‘existential distress’. The question was intended to elicit information about the patient’s state of mind, not to suggest that option to the patient. But, if this Bill is passed, then it will be necessary to curtail the discussion, to prohibit doctors from making this suggestion.

5.4. Reverse the presumption of capacity/competence. This presumption has its home in medicine’s therapeutic ethic. In that context, the doctor proposes a treatment or range of alternative treatments, and the patient accepts or refuses. The primary decision-maker is the patient: he or she is the person with the responsibility for making decisions about what treatments to accept or refuse. And the community cares so much about honouring this responsibility that we presume competence unless there is evidence to the contrary. The matter is entirely different when what is at stake is assistance to end one’s own life. A minority of people who are ‘rationally autonomous’ will clearly have capacity to make this request for assistance. But most to whom it will be suggested will not: they will be too frail, or too anxious, or too depressed or demoralized, to know what is going on and may well be subject to the subtle coercive pressure of family who have had enough. They should not be presumed to be competent.

I would be happy to answer any questions the Committee might have about my submission.

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24.11.21

Appendix

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It’s inevitable that rules on euthanasia will be expanded

BERNADETTE TOBIN

To legalise so-called voluntary assisted dying is to legalise a practice that predictably and inevitably expands. There is plenty of evidence of bracket creep already in Australia and overseas.

From 2017 in Victoria through to this year in Queensland, the circumstances in which this service has been made available have widened as bills have been debated in state jurisdictions.

So, too, in NSW from 2017 when the state parliament debated the Khan Bill to this year when it debates the Greenwich Bill: once again the conditions under which the service is to be available have expanded.

And there’s plenty of evidence of the same phenomenon from Europe and Canada.

Expansion should not surprise us. More important, however, than acknowledging these empirical facts is understanding why they have occurred.

There are, I think, two forms of pressure that cause this by-now familiar expansion of the laws. I will call the first pressure “choice will not be necessary” and the second pressure “choice will be the only thing that’s necessary”.

The “choice will not be necessary” pressure works like this. The patient chooses VAD. Then two doctors assess the person’s eligibility: a medical condition from which the patient will likely die soon, from which the patient is suffering intolerably. The doctors must judge whether these criteria are met. But, if someone else meets these criteria, why will choice be necessary? Why not expand the availability to people who meet these eligibility criteria but who cannot choose?

The pressure to expand availability in this direction can be seen in the arguments of those who say euthanasia should be made available for newborn babies (as in The Netherlands) and/or to people with dementia (as in Canada).

Indeed, years ago the late Dr Rodney Syme, a proponent of these laws, predicted that once the service was legally available to those who could choose it, society might come to think that it would be unfair if it were not available to people who could not choose it. His reference was to people with dementia. Thus, the “choice will not be necessary” prediction.

The “choice will be the only thing that’s necessary” pressure goes in the other direction. A patient chooses VAD. Then the doctors must assess the patient’s eligibility. But the doctors, understandably, are likely to shy away from making what is mostly a medical judgment (that the patient meets the eligibility criteria) and prefer to rely on the actual choice of the patient.

The pressure to expand availability in this direction to anyone who chooses can be seen in Canada, where the requirement that death must be reasonably foreseeable has been dropped on the grounds that requirement discriminates against people with serious disabilities who are not terminally ill. Thus, the pressure towards “choice will be the only thing that is necessary” prediction.

These two forms of pressure, which seem to go in opposite directions, in fact share an assumption: that we can know when a life is not worth living.

In the former case, that assumption is made “objectively” by others. In the latter case, that assumption is made “subjectively” by the person themselves.

This is why most of the debate about adequacy of the safeguards in these bills misses the point.

However humane one’s motives in supporting these laws, the likelihood of the criteria of eligibility being expanded cannot be set aside as though it were mere panic-mongering.

Parliamentarians, in framing laws for the wellbeing of everyone in the community, have a responsibility to deepen and widen their thinking.

The social policy before them is not simply a matter of how best to ensure that people do not die in unrelieved suffering. It is also a matter of how to protect the lives of those who, on their own or at the behest of others, have come to think their lives are not worth living. Their existential demoralisation is a challenge to us all.

Yes, I’m a Catholic, so it will be said I’m trying to impose my religious beliefs on those who don’t share them. Well, any reasonable religion holds out its social teachings as matters that are apt for rational assessment.

But, that said, there is nothing religious in the claim that expansion of these laws is predictable and inevitable.

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